88-1520

No.

Supreme Court, U.S.
FILED
MAR 15 1989
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

MEDICAL MALPRACTICE INSURANCE ASSOCIATION,

Petitioner,

v.

SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

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QUESTIONS PRESENTED

1. Whether, as suggested by the decision below, a state may create a privately-funded and controlled legal entity that has no right to assert a claim of confiscation under the fifth and fourteenth amendments of the United States Constitution.

2. Whether a state may compel an insurer to provide insurance coverage for the benefit of a particular group of policyholders at rates that will require the insurer to operate at a deficit for at least fifteen years.

PARTIES TO THE PROCEEDING BELOW

On the appeal to the Court of Appeals of the State of New York, the respondent, Superintendent of Insurance of the State of New York, was the respondent-appellant. The petitioner, Medical Malpractice Insurance Association, was petitioner-respondent.

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SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

Petitioner, Medical Malpractice Insurance Association ("MMIA"), respectfully requests that a writ of certiorari issue to review the judgment of the Court of Appeals of the State of New York, issued and entered on December 15, 1988, reversing an order of the Supreme Court of the State of New York, Appellate Division, First Department, which had affirmed a judgment of the trial court.

OPINIONS BELOW

The opinion of the Court of Appeals of the State of New York (App. A)[1] is reported at 72 N.Y.2d 753, 533 N.E.2d 1030,

1 Parenthetical references to "App." refer to the Appendices to this Petition. Parenthetical references to "A." and "SA." refer to pages of the Appendix and Supplemental Appendix of the respondent in the proceedings below. Parenthetical references to "RA." refer to pages of the Appendix of MMIA in the proceedings below.

537 N.Y.S.2d 1. The opinions of the Supreme Court of the State of New York, Appellate Division, First Department, are reported at 143 A.D.2d 551, 532 N.Y.S.2d 491 (App. B) and 141 A.D.2d 475, 531 N.Y.S.2d 503 (App. C). The opinion of the Supreme Court of the State of New York, County of New York (App. D), is reported at 137 Misc. 2d 785, 520 N.Y.S.2d 501.

JURISDICTION

The judgment of the Court of Appeals of the State of New York was issued and entered on December 15, 1988. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

MMIA contends that section 40 of chapter 266 of the 1986 Laws of New York ("section 40"), which was implemented by respondent in the Tenth Amendment to Regulation 101, N.Y. Comp. Codes R. & Regs. tit. 11, § 70.8 (1987), violates the fifth and fourteenth amendments to the United States Constitution, U.S. Const. amends. V and XIV, § 1.

STATEMENT OF THE CASE

The Parties

MMIA is a non-profit, unincorporated joint underwriting association ("JUA"), N.Y. Ins. Law § 5502 (McKinney 1985 & Supp. 1989),[2] established by the New York State Legislature in 1975 to provide a market for medical malpractice insurance (A. 1028-29). All insurance companies directly writing personal injury liability insurance in New York are required to be members of MMIA. N.Y. Ins. Law § 5502(a) (McKinney 1985).

2 While MMIA is an unincorporated association, it is also a "legal entity separate and distinct from its members." N.Y. Ins. Law § 5502(b) (McKinney 1985). MMIA in this proceeding therefore asserts constitutional rights on behalf of itself and its members.

Presently, MMIA comprises approximately 350 member insurers domiciled in over twenty-five states.

MMIA is neither an agency nor a branch of the State Government and does not receive funding from the State Treasury. Member companies may be assessed for certain operating expenses, including deficits arising from operations. N.Y. Ins. Law §§ 5503(b), 5507(b) (McKinney 1985). MMIA is governed by a board of fifteen directors: eight elected by the member companies; six appointed by the Superintendent as representatives of physicians, hospitals and the public; and the Superintendent as a non-voting director. N.Y. Ins. Law § 5508(a) (McKinney 1985).

MMIA is required to provide separate policies of primary and excess professional liability insurance up to an annual aggregate of $9 million, upon application of any physician or surgeon licensed in New York. N.Y. Ins. Law §§ 5502(e), 5506 (McKinney 1985 & Supp. 1989); N.Y. Comp. Codes R. & Regs. tit. 11, § 70.9(c)(1) (1988) (Twelfth Amendment). MMIA's ability to meet loss and expense obligations incurred under the policies is contingent upon collection during each year of sufficient premium income derived from actuarially sound rates. In the event that premium income is inadequate to offset loss and expense obligations, the member companies are subject to assessment, without limitation, for the resulting operating deficits. N.Y. Ins. Law § 5507(b) (McKinney 1985). MMIA and its members also may be assessed by New York's Property/Casualty Insurance Security Fund ("Security Fund") when the Security Fund's net assets fall below $150 million as a result of paying claims on behalf of insolvent insurers, including other New York medical malpractice insurers. N.Y. Ins. Law § 7603(a), (c) (McKinney 1985 & Supp. 1989).

Respondent, the Superintendent of Insurance of the State of New York ("the Superintendent"), is the head of the Insurance Department of the State of New York ("the Department"). N.Y. Ins. Law § 201 (McKinney 1985).

Prior to the policy year commencing July 1, 1985, rates for all medical malpractice insurers in New York, including

MMIA, were filed by the insurers with the Superintendent and were subject to his approval. *See* N.Y. Ins. Law § 2305(b) (McKinney 1985). The Superintendent has never approved an adequate rate in any year since MMIA's inception (RA. 12).[3] As a result, New York's major writers of medical malpractice insurance had incurred a combined deficit, as of December 31, 1985, of $1.5 billion (A. 1004-05, 1024, 1267).[4] MMIA's share of this deficit was $80-$85 million (A. 1005).[5] *See also Alliance of Am. Insurers v. Cuomo*, 854 F.2d 591, 594 (2d Cir. 1988).

The combined $1.5 billion deficit, as of December 31, 1985, was already over six times the total amount of money available

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3 As the Superintendent stated in his statutorily-mandated Report to the Governor and the Legislature:

> Every year on the chart [1959 through 1976] shows huge premium deficiencies. For each policy year, premium funds and investment income ran out from 6 to 10 years later. Further, the insurers should have collected about 30% to 200% more in premium each year to adequately pay for the losses they incurred.
>
> . . . .
>
> . . .[I]t is clear (with hindsight) that substantial rate deficiency has been the rule, at least from 1959 through 1979. The accident years since 1979 have been exhibiting a similar pattern of rate deficiency.

N.Y. Ins. Dep't, *A Balanced Prescription For Change: Report of the New York State Insurance Department on Medical Malpractice* 73-74 (1988) ("Department's Report").

4 The principal writer of medical malpractice insurance in New York is the Medical Liability Mutual Insurance Company ("MLMIC"). MLMIC has not sought judicial relief from the Superintendent's inadequate rate determinations because it is owned and operated by insured physicians. In the event it becomes insolvent as a result of inadequate rates, MLMIC's policyholder members will be protected by the Security Fund and will not be assessed any additional premiums (*see* RA. 78-85). MLMIC's rate filings have been found to be improperly influenced by business decisions and other non-actuarial factors (A. 596).

5 This deficit exists even after transfer and utilization of all stabilization reserve fund ("SRF") charges collected by MMIA pursuant to the Insurance Law, *see* N.Y. Ins. Law § 5509 (McKinney 1985 & Supp. 1989). The Department expressly acquiesced in MMIA's use of the SRF charges to reduce its operating deficit. *See MMIA v. Cuomo*, 138 A.D.2d 177, 181, 531 N.Y.S.2d 231, 232 (1st Dep't), *leave to appeal granted*, 143 A.D.2d 548, _____ N.Y.S.2d _____ (1st Dep't 1988).

from the Security Fund. *See* N.Y. Ins. Law § 7603 (McKinney 1985 & Supp. 1989). The annual interest charge on this deficit alone exceeds the maximum annual assessment that could be levied on insurers in New York under the applicable Security Fund statute (A. 1266-68). *See* N.Y. Ins. Law § 7603(b), (c) (McKinney 1985).

Recognizing the magnitude of these deficits and the continuing losses being incurred by MMIA and other medical malpractice insurers, the New York Legislature, effective July 1, 1985, suspended the Superintendent's authority to seek the rehabilitation or liquidation of any New York medical malpractice insurer because of insolvency. 1985 N.Y. Laws ch. 294, § 16, *as amended by* 1986 N.Y. Laws ch. 266, § 8, *as amended by* 1988 N.Y. Laws ch. 184, § 7 (codified at N.Y. Ins. Law § 2343(c) (McKinney Supp. 1989)).

Notwithstanding MMIA's substantial existing deficit as of December 31, 1985, the Department disapproved MMIA's filing for adequate rates for both primary and excess policies for the 1985-86 policy year. In response, MMIA sought and obtained an administrative hearing on the rate disapproval before retired New York Court of Appeals Judge Matthew J. Jasen, who sat as a Special Deputy Superintendent. After a six-day evidentiary hearing, Judge Jasen found that MMIA was entitled to an 86.7% rate increase for the 1985-86 policy year (A. 595).

However, before Judge Jasen's findings could be implemented, the Legislature in July, 1986 enacted chapter 266 of the 1986 Laws of New York ("the 1986 Act"), which, *inter alia*, directed the Superintendent to set physicians and surgeons professional liability rates, retroactive to July 1, 1985, for each policy year 1985-86, 1986-87 and 1987-88. An announced purpose of the enactment was to "restrain" rate increases required by the insurers. 1986 N.Y. Laws ch. 266, § 1. The 1986 Act also authorized future Superintendents, commencing July 1, 1989, to impose an annual surcharge of up to 8% of "an approved adequate rate" in order "to satisfy any actuarially projected deficiency that is attributable to the premium levels estab-

lished'' in each of the 1985-88 policy years. 1986 N.Y. Laws ch. 266, § 40.[6]

The 1986 Act and related legislation included certain changes in the substantive and procedural rules affecting medical malpractice lawsuits in the State.[7] The changes, together with the restraint on premiums, were intended to deal with the ''rising cost of health care'' in the State. 1986 N.Y. Laws ch. 266, § 1.[8] It is generally agreed that the effect of such tort law changes on medical malpractice insurance costs are uncertain and unquantifiable. *See* N.Y. Ins. Dep't, *A Balanced Prescription For Change: Report of the New York State Insurance Department on Medical Malpractice* 79-86 (1988) (''Department's Report'').

Similar tort law changes in several states have been found to have little effect on insurance costs. *See* U.S. Gen. Accounting Office, Report to Congressional Requesters, Pub. No. GAO/HRD-87-21, *Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms* (1986). Additional studies also show that ''tort reforms'' have not had their intended effect on insurance costs. *See* Sloan, *State Responses to the Malpractice Insurance ''Crisis'' of the 1970s:*

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6 Section 40 of the 1986 Act was subsequently amended, *inter alia*, to extend the Superintendent's rate-setting authority to policy years 1988-89, 1989-90 and 1990-91 and increase the maximum assessable surcharge to 25% commencing July 1, 1991. 1988 N.Y. Laws chs. 184, § 19 & 186, § 1 (''the 1988 Act'').

7 The changes enacted in 1986 included: certification of the merit of malpractice complaints, reduction in joint and several liability, revision of the appellate review standard, voluntary arbitration and mandatory claims-made policies for new insureds. 1986 N.Y. Laws chs. 266, 682. These changes were in addition to tort law changes enacted in 1985, which included: periodic payment of judgments, limitations on contingency fees, reduction of awards for future collateral source payments, penalties for frivolous claims and defenses, and various changes to speed up pre-trial and trial procedures. 1985 N.Y. Laws ch. 294.

8 Medical malpractice premiums reportedly make up less than 1% of total health care costs. *See* U.S. Gen. Accounting Office, Report to Congressional Requesters, Pub. No. GAO/HRD-86-112, *Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals* 25 (1986).

An Empirical Assessment, 9 J. Health Pol., Pol'y & L. 629, 643 (1985).

Pursuant to provisions of the 1986 Act, the Superintendent—without conducting any hearings in which MMIA or its member companies could participate—established rates for the 1985-86, 1986-87 and 1987-88 policy years (App. G). Despite Judge Jasen's finding of a need for an 86.7% increase for the year commencing July 1, 1985, the Superintendent increased the rates for that year by only 14%, with subsequent increases of only 9% for each of the 1986-87 and 1987-88 policy years.

MMIA commenced a proceeding in the Supreme Court, County of New York ("trial court"), challenging the Superintendent's determination on the grounds, *inter alia*, that it was made in violation of lawful procedure and in violation of the fifth and fourteenth amendments of the United States Constitution.

Judgment of the Trial Court

The trial court referred the proceeding to a referee for a hearing (A. 107-09). At the hearing, the Superintendent did not dispute MMIA's contention that the rates that he had established for policy years 1985-86, 1986-87 and 1987-88 were, in themselves, grossly inadequate (A. 979; *see also* A. 203-04). In fact, the Superintendent's chief actuary testified that the rates for these years likely would impose huge additional deficits on New York medical malpractice insurers (A. 1197-98, 1221-22). The amount of the additional deficits would total at least $1.6 billion (A. 1197-98, 1221-22, 1283, 1287; *see also* A. 314, 961). This deficit amount was on top of the existing combined MMIA/MLMIC deficit, as of December 31, 1985, of $1.5 billion (A. 1004-05, 1024, 1267; *see also* A. 1084-85; RA. 12-13).

The only evidence offered by the Superintendent in support of his rate determinations consisted of what his witness termed "scenario" projections performed by two Department actuaries in response to hypothetical questions (A. 985-86, 988, 1230-

31).[9] The "scenario" projections suggested that the $1.6 billion additional deficit could be recouped through indeterminable future premium surcharges authorized by the 1986 Act. The Superintendent's chief actuary testified that—even assuming the most optimistic of his assumptions, including collection in future years of the largest surcharge legally permissible—the additional deficits likely would not be cured before the year 2000 (A. 314, 1124). This is a period of more than fifteen years from the effective date of the initial deficit rates set by the Superintendent.

With respect to the 1986 legislative tort law changes, the Superintendent's actuary projected only a 5% to 6% reductive effect on the required rate level, thereby reducing Judge Jasen's recommended 86.7% increase for policy year 1985-86 to 76% (RA. 88). However, the Superintendent reduced the amount of the increase to only 14% instead of 76% (App. G). Previously, the actuaries had determined that the 1985 tort law changes would reduce the 1984-85 policy year rate level by only 6%, but the Superintendent had implemented a 15% reduction instead (A. 78, 324).

The Superintendent's actuary testified further that he had advised the Superintendent that the future surcharges would cure the deficits by the year 2000 only "if an otherwise adequate rate were charged commencing policy year 1988." (RA. 4). He had reported to the Superintendent that, based on his projections, the minimum rate level increase required for the policy year 1988 would be 135% (A. 314, 318, 987-88, 1125-26, 1132). Thereafter, rates would have to be maintained at an adequate level in each year in order for MMIA's deficit to be cured within the projected fifteen-year period (RA. 4).[10]

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9 The Department's principal actuarial witness emphasized that the "scenario" projections did not constitute actuarial analysis (A. 985-86, 1231; RA. 16).

10 The subsequent enactment of the 1988 Act, *see supra* p. 6, note 6, made clear that rates commencing policy year 1988, in fact, would

Other unrealistic assumptions included in the actuary's projections were that the number of doctors insured in future years would remain relatively constant, in spite of required large rate increases plus the surcharges on premiums (A. 1023-24, 1038-39, 1059-66, 1067-70),[11] and that the surcharges in fact will be imposed on, and collected from, future generations of physicians who have derived no benefit from the former inadequate rates. The Department's principal actuary admitted that his "scenario" projections required "looking for appropriate rates for policy years 15 years into the future,-and making extrapolations into a very uncertain area based on what we know." (A. 990).

Although finding that the rates established by the Superintendent were inadequate when considered without the future surcharges, the referee recommended that the determination of the Superintendent as to primary rates be upheld, stating that he found no unconstitutionality in requiring MMIA's members to provide a "less desirable . . . kind of service that the Legislature determines is needed, as a condition of doing the more desirable kind of business in the state." (A. 210). After extensive scrutiny of the record, the trial court rejected this recommendation of the referee.

The trial court distinguished a state's power to require MMIA's members to participate in a JUA as a condition of

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not be brought to adequate levels. 1988 N.Y. Laws chs. 184, 186. Under that legislation's extension of the Superintendent's rate-setting authority, the Superintendent has increased physicians and surgeons rates by only 5%, instead of the minimum 135% envisioned by his actuary's projections. N.Y. Comp. Codes R. & Regs. tit. 11, § 70.9(c)(1)(i) (1988) (Twelfth Amendment).

11 Although the Superintendent in the proceedings below contended that an annual surcharge of 25% on top of a greatly increased premium, effective July 1, 1991, will recoup MMIA's losses for the current years, he has separately reported to the Governor and Legislature that physicians would "go bare," *i.e.*, refuse to purchase malpractice coverage, if currently faced with a premium increase of only 32% (Department's Report at 87). If physicians "go bare" when confronted with greatly increased rates plus a 25% surcharge in 1991, there will be no one to pay the surcharge to make up MMIA's deficit.

their doing business in the state from the power to compel the JUA to do business at a loss for the benefit of others:

> That MMIA was created as a non-profit corporation and that membership in MMIA by the member insurers is a condition of their doing business in this State does not give the State, acting through the Superintendent's rate-making powers, the power to require them to invest in or to maintain a losing business for the benefit of others.

(App. D at 33a). Acknowledging that the Legislature's purpose in enacting the tort law changes was to stabilize malpractice rates for the state's physicians, the trial court nonetheless found that:

> It would be impermissible for the Legislature to effectuate that purpose by requiring that the Superintendent act in such a way as to effectuate an unconstitutional result, which would be the case if the statute were to be read to require rates that did not allow a reasonable rate of return to the petitioner or to its members.

(App. D at 30a). The trial court thereupon entered judgment annulling the Superintendent's rate determinations.

Affirmance by the Appellate Division

On appeal by the Superintendent, the Appellate Division of the New York Supreme Court, First Department, affirmed for the reasons stated by the trial court, with two Justices dissenting (App. C at 17a). The dissent rejected MMIA's argument that the imposition of rates compelling it to operate at a loss violates the fifth and fourteenth amendments of the United States Constitution (App. C at 24a).

The Superintendent moved the Appellate Division for reargument and renewal of his appeal (SA. 16-17). The Appellate Division denied the motion to reargue, granted the motion to renew, and, upon renewal, adhered to the determination made in its prior order (App. B).[12]

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12 The reason for the grant of renewal was that the Legislature's enactment of the 1988 Act occurred one day after the initial decision of the

Reversal by the Court of Appeals —

The New York Court of Appeals reversed the order of the Appellate Division, dismissed MMIA's petition and reinstated the determination of the Superintendent as to both primary and excess rates (App. A).[13] Writing for a unanimous court, Judge Vito J. Titone noted that although the rates set by the Superintendent are inadequate and inconsistent with MMIA's solvency, section 40 authorizes the Superintendent to set present inadequate rates in contemplation of the future surcharges (App. A at 5a, 7a-9a). Judge Titone recognized that the surcharges had not been set, nor could they even be determined, until future years (App. A at 4a-5a). He also acknowledged that the rates "are entirely inadequate" without consideration of the future indeterminable surcharges (App. A at 5a). The decision stated that "MMIA may well be forced to run at a deficit until the surcharges result in recoupment in approximately the year 2000." (App. A at 11a).

The court found the fifteen-year period for recoupment to be "not unreasonable" because MMIA likely would have enough cash to pay claims as they come due through the recoupment period (App. A at 12a). In support of this finding, the court cited the projections of the Superintendent's chief actuary. As

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Appellate Division. The Legislature stated in the 1988 Act that one of the purposes was to "clarify the nature of the authority of the superintendent of insurance to establish rates in view of a judicial decision [by the trial court] that has misconstrued the intent of the legislature." 1988 N.Y. Laws ch. 184, § 1. In spite of this legislative pronouncement, the Appellate Division adhered, upon renewal, to the reasoning of the trial court.

13 In upholding the Superintendent's determination as to excess rates, the Court of Appeals took judicial notice of a Regulatory Impact Statement filed by the Superintendent after the referee had issued his report (App. A). To the extent that the Regulatory Impact Statement does not state the law of New York, but merely findings or conclusions of the Superintendent, the court's taking of judicial notice was inconsistent with this Court's decision in *Ohio Bell Telephone Co. v. Public Utilities Commission*, 301 U.S. 292, 296-303 (1937), especially since MMIA had no opportunity to rebut those findings and conclusions.

noted above, the actuary had testified that his projections involved "looking for appropriate rates for policy years 15 years into the future, and making extrapolations into a very uncertain area based on what we know." (A. 990).

Although the decision below recognized that the computations of the Superintendent's actuary were founded upon "the Superintendent's willingness to permit 'adequate' increases beginning in 1988-89 and the following years" (App. A at 10a), the court did not consider legislation and a regulatory amendment, which became effective July 1, 1988, that put off adequate rates for another three years. Pursuant to the 1988 Act, *see supra* p. 6, note 6, the Superintendent—acting on the Legislature's extension of his rate-setting authority—increased the rates for the policy year commencing July 1, 1988 by only 5%, instead of the 135% assumed to be necessary in the projections of his actuary. The Superintendent has indicated that the rates for each of the policy years 1989-90 and 1990-91 also will be increased by only 5%. *See* N.Y. St. Reg., Aug. 17, 1988, at 23 (Regulatory Impact Statement).

The decision below, without citation to any support in the record, stated that, "If the [tort] reforms have their expected salutary effect, the collection of unnecessarily high premiums will be avoided." (App. A at 12a).

With respect to MMIA's claims under the fifth and fourteenth amendments of the United States Constitution, the court below held as follows:

> Finally, we reject MMIA's claim that section 40 is confiscatory as to it. MMIA was created by the Legislature of the State of New York in order to provide much needed medical malpractice insurance. MMIA is a creature of statute, and all of its rights, obligations and duties have been defined by the Legislature (*see*, Insurance Law art 55). . . .
>
> Thus, as a statutory entity created by the Legislature, the State's broad police power can be implemented to fos-

ter affordable medical malpractice coverage, with the possibility that MMIA will operate under a deficit.

(App. A at 12a-13a).

The court further ruled that, "even if MMIA will operate at a continued loss, such a loss is not confiscatory vis-à-vis MMIA," citing this Court's decision in *Brooks-Scanlon Co. v. Railroad Commission*, 251 U.S. 396 (1920) (App. A at 13a).

Although the constitutional rights of MMIA's members were decided by the referee, the trial court and the Appellate Division (*see* Apps. B, C, D), the New York Court of Appeals declined to consider the rights of MMIA's members because they were not named parties in the proceeding.

REASONS FOR GRANTING THE WRIT

I

In Holding that a State-Created Legal Entity, Privately Funded and Controlled, Has Only the Rights Assigned to It by the State Legislature, so that It Cannot Assert a Claim of Confiscation Under the Fifth and Fourteenth Amendments of the United States Constitution, the Decision of the Court Below Conflicts with Applicable Decisions of this Court

In support of the proposition that MMIA, as "a creature of statute," can be compelled to operate at a deficit in order to provide "affordable medical malpractice coverage" to the State's physicians (App. A at 13a), the New York Court of Appeals cited this Court's decision in *Brooks-Scanlon Co. v. Railroad Commission*, 251 U.S. 396 (1920). However, *Brooks-Scanlon* does not support the holding of the court below. To the contrary, this Court's teaching in that case was that a state-chartered corporation cannot be compelled to carry on even a branch of its business at a loss. *Id.* at 399.

The decision of the New York Court of Appeals relied on the following *dictum* from *Brooks-Scanlon*:

> It is true that if a railroad continues to exercise the power conferred upon it by a charter from a state, the state may require it to fulfil an obligation imposed by the charter, even though fulfilment in that particular may cause a loss.

Id. However, beyond that *dictum*, Justice Holmes, writing for the Court, continued as follows:

> But that special rule is far from throwing any doubt upon a general principle too well established to need further argument here. The plaintiff may be making money from its sawmill and lumber business, but it no more can be compelled to spend that than it can be compelled to spend any other money to maintain a railroad for the benefit of others who do not care to pay for it. If the plaintiff be taken to have granted to the public an interest in the use of the railroad, it may withdraw its grant by discontinuing the use when that use can be kept up only at a loss. The principle is illustrated by the many cases in which the constitutionality of a rate is shown to depend upon whether it yields to the parties concerned a fair return.

Id. (citation omitted).

Unlike a private railroad corporation mentioned in the special rule by the *Brooks-Scanlon* Court, MMIA is not voluntarily choosing to continue doing business under its state charter. To the contrary, MMIA is compelled by statute to continue providing insurance coverage to New York's physicians. It is not free to withdraw from the business. Accordingly, it is clear under the holding of *Brooks-Scanlon* that MMIA cannot be compelled to operate at a loss.

Similarly, the two other decisions of this Court cited by the New York Court of Appeals do not support the proposition that MMIA can be compelled to operate its business at a loss. *Atlantic Coast Line Railroad v. North Carolina Corporation Commission*, 206 U.S. 1 (1907), and *Missouri Pacific Railway v. Kansas ex rel. Taylor*, 216 U.S. 262 (1910), each involved an order of a state agency requiring a railroad company to operate a particular branch line as an incident to its charter to operate

railway service within the state. This Court in both cases was careful to draw a distinction between requiring a state-chartered entity to perform a particular duty, even though unprofitable, as an incident to the continued enjoyment of its charter and requiring the company to operate under confiscatory rates affecting the profitableness of the entire operation.

> This is so [the distinction] because, as the primal duty of a carrier is to furnish adequate facilities to the public, that duty may well be compelled, although by doing so, as an incident, some pecuniary loss from rendering such service may result. It follows, therefore, that the mere incurring of a loss from the performance of such a duty does not, in and of itself, necessarily give rise to the conclusion of unreasonableness, as would be the case where the whole scheme of rates was unreasonable under the doctrine of Smyth v. Ames, 169 U.S. 526, 42 L. ed. 842, 18 Sup. Ct. Rep. 418.

Missouri Pac. Ry., 216 U.S. at 278 (quoting, with approval, *Atlantic Coast Line R.R.*, 206 U.S. at 26).

The *Missouri Pacific* Court noted that the incidental pecuniary loss "is a necessary consequence of the acceptance and continued enjoyment of its corporate rights, those rights not having been surrendered by the corporation . . . ." *Id.* at 279. In the present case, MMIA did not voluntarily accept its charter. Nor has it continued to enjoy any privileges under the charter. Instead, it has been compelled by the State to provide insurance to a particular group of State residents, and it is not free to withdraw from the business. Consequently, MMIA cannot be compelled to operate its business at a loss.

Clearly, the New York Court of Appeals has erroneously departed from the teachings of this Court in the three cases that it has cited in support of its holding. The decision below also conflicts with other applicable decisions of this Court.

This Court long ago in *Smyth v. Ames*, 169 U.S. 466 (1898), established that the fifth and fourteenth amendments of the United States Constitution require that state-prescribed rates

not be confiscatory. Justice Harlan, writing for the Court, stated:

> [I]t cannot be admitted that the power granted [to set rates] may be exerted in derogation of rights secured by the Constitution of the United States, or that the judiciary may not, when its jurisdiction is properly invoked, protect those rights.

Id. at 527.

In *Newton v. Consolidated Gas Co.*, 258 U.S. 165 (1922), this Court held that where the prescribed rate had yielded no fair return for more than a year, and that this condition would almost certainly continue for many months, "the company was clearly entitled to relief." *Id.* at 175.

In *West Ohio Gas Co. v. Public Utilities Commission*, 294 U.S. 79 (1935), the state regulatory agency had taken the position—similar to that of the Superintendent in the present case—that any inadequacies in the established rates would be made up by future increased revenues that would result from a projected increase in the company's volume of business. *Id.* at 82-83. Justice Cardozo, for a unanimous Court, rejected this argument stating:

> Upon the record as it comes to us, this is guesswork, and no more. . . . *Present confiscation is not atoned for by merely holding out the hope of a better life to come.*

Id. at 83 (emphasis added).

In *California State Automobile Association Inter-Insurance Bureau v. Maloney*, 341 U.S. 105 (1951), this Court considered the power of a state to compel automobile insurers to participate in a state-mandated automobile insurance pool that offered insurance to those unable to obtain it in the commercial market. While upholding the state's power to compel participation in the pool in order to serve the public interest, *id.* at 109-10, this Court observed that:

> [T]here are important restrictions on the financial commitments incident to the broadened undertaking. We were

> advised on the argument that the premiums chargeable can be commensurate with the greater risks of the new business. Confiscation is therefore not a factor in the case.

Id. at 108.

In the present case, the premiums chargeable are not commensurate with the risks that MMIA and its members are compelled to assume. The decision below recognized that MMIA likely "will operate at a continued loss" (App. A at 13a) and "may be forced to run at a deficit until . . . the year 2000." (App. A at 11a). Thus, unlike *Maloney*, confiscation is manifest in this case.

The suggestion of the court below that the higher premiums may become unnecessary because of the tort law changes is contradicted by the facts. The Superintendent's own actuaries attributed only a minimal reductive effect to the measures enacted by the Legislature. They would have reduced the necessary 1985-86 rate increase of 86.7% only to 76% (RA. 88). However, the Superintendent reduced the increase to 14%. Previous studies have demonstrated that tort law changes have had little effect on medical malpractice insurance costs. *See* U.S. Gen. Accounting Office, Report to Congressional Requesters, Pub. No. GAO/HRD-87-21, *Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms* (1986). Indeed, the Superintendent's report to the Governor and Legislature discussed in some detail the difficulty in quantifying the value of tort law changes (Department's Report 79-86), and noted, significantly, as follows:

> Policies covering medical malpractice are generally nonassessable, so that if there is any overestimation of the savings attributable to tort reforms, the resulting deficiency cannot be directly recouped from the policyholders who were charged an inadequate rate.

Department's Report at 80-81.

This court has made clear that actual experience must be considered when evaluating rate standards. *See West Ohio Gas Co. v. Pub. Utils. Comm'n*, 294 U.S. 79 (1935). The court below

ignored actual experience when it relied on the computations of the Superintendent's actuary in concluding that MMIA's deficit would be made up by the year 2000 (App. A at 10a, 12a). The court failed to consider the fact that a major premise of the actuary's computations had not been fulfilled, *i.e.*, "the Superintendent's willingness to permit 'adequate' increases beginning in 1988-89 and the following years" (App. A at 10a). Pursuant to legislation effective July 1, 1988 (*see supra* p. 6, note 6), the Superintendent set the 1988-89 rate level increase at only 5%, instead of the 135% found necessary in his actuary's computations. Therefore, the available evidence showed that the computations were flawed and could not be relied upon for the proposition that MMIA's deficit will be recouped even by the year 2000.

Writing for the Court in *West Ohio Gas Co.*, Justice Cardozo stated:

> But prophecy, however honest, is generally a poor substitute for experience. "Estimates for tomorrow cannot ignore prices of today." . . . "[E]laborate calculations which are at war with realities are of no avail."

294 U.S. at 82 (citations omitted).

The speculative and unquantifiable nature of the surcharges is inconsistent with the well-settled rule of this Court that compensation for a taking must be certain, *Cherokee Nation v. Southern Kansas Ry.*, 135 U.S. 641, 659 (1890), and is due at the time of the taking, *United States v. Dow*, 357 U.S. 17, 20-21 (1958). As the court below recognized, the amount of the future premium surcharges have not been set nor can they even be calculated. Although the surcharge is to be applied to "approved adequate rates" in the future, those future rates themselves cannot be determined until later years.

There is no assurance that the surcharge will be implemented by future Superintendents, if at all, at the levels and for the duration now claimed to be necessary to fund the state-imposed deficits. If implemented, the surcharge may be subject to legal challenges by policyholders who object to subsidizing past poli-

cyholders. Moreover, when faced with a surcharge, policyholders may choose to forego insurance, insure in alternative markets or leave the state. MMIA cannot constitutionally be forced to assume the full burden of the loss and expense obligations incurred under policies issued during each of the 1985-88 policy years in the hope that future generations of policyholders, if any, will be willing and able to pay future surcharges, particularly where many of the future policyholders will have received no benefits under the earlier policies. Without ratepayers, MMIA's deficit will not be recovered.

The court below carved out an exception to the due process and "taking" clauses of the fifth and fourteenth amendments. According to the decision, a state-created entity can be precluded from a claim of confiscation on the ground that it is "a creature of statute, and all its rights, obligations and duties have been defined by the Legislature" (App. A at 13a). The applicable decisions of this Court do not permit such an exception. This Court has made clear that state-prescribed rates cannot be confiscatory. Since the decision below has upheld confiscatory rates, review by this Court is required by writ of certiorari to the New York Court of Appeals.

II

The Decision of the New York Court of Appeals Holding that an Insurer May Be Compelled To Operate at a Loss Under the Fifth and Fourteenth Amendments of the United States Constitution Conflicts with Decisions of Other State Courts of Last Resort

On facts similar to those before the Court on this petition, the Supreme Court of North Carolina rejected, as inconsistent with the fourteenth amendment, a statutory scheme that would have compelled all liability insurers doing business in North Carolina to be members of a non-profit, unincorporated legal entity designated the North Carolina Health Care Liability Reinsurance Exchange ("the Exchange"). *Hartford Accident & Indemn. Co. v. Ingram*, 290 N.C. 457, 226 S.E.2d 498 (1976).

The statutory scheme in *Hartford Accident* required the insurers to provide medical malpractice coverage to any applicant, with the right to shift 100% of the risk assumed to the Exchange. *Id.* at 462-65, 226 S.E.2d at 502-03.

Although noting that North Carolina had a strong public policy obligation to ensure the availability of medical malpractice insurance, the state's highest court declared that "it does not necessarily follow that the State has power to conscript certain persons or corporations, or a certain group thereof, and require such draftees to supply the need at their risk or expense."[14] *Id.* at 467, 226 S.E.2d at 505. Although the statutory scheme called for the establishment of "adequate" and "reasonable" rates, the court held that the scheme was nonetheless unconstitutional, in that the member insurers of the Exchange would still bear an undesired risk of loss:

> The losses and expenses "anticipated" by the Commissioner in the establishment of premium rates may easily prove substantially less than those actually incurred. The record shows, with disturbing clarity, that this has been the experience in the past . . . .

Id. at 469, 226 S.E.2d at 506.

Similarly, the court rejected an argument that because the insurers could cede 100% of every risk to the Exchange, the statute was not constitutionally suspect. *Id.* at 468, 226 S.E.2d at 506. The court noted that North Carolina's statute provided that in the event of losses to the Exchange, its member insurers

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14 In support of this proposition, the North Carolina court cited with approval this Court's decision in *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393 (1922), in which Justice Holmes stated:

> In general it is not plain that a man's misfortunes or necessities will justify his shifting the damages to his neighbor's shoulders. We are in danger of forgetting that a strong public desire to improve the public condition is not enough to warrant achieving the desire by a shorter cut than the constitutional way of paying for the change.

Id. at 416 (citation omitted).

were assessable to the extent of such losses. *Id.* Thus, the court found that while the risks underwritten could be shifted to the Exchange, an undesired risk of loss nonetheless unconstitutionally remained with the member insurers. *Id.* at 468-69, 226 S.E.2d at 506.

Like the liability insurers in *Hartford Accident*, MMIA's members are involuntarily compelled to participate in a state-created JUA and are ultimately responsible for losses resulting from the establishment of inadequate rates chargeable by the JUA. Furthermore, the record shows "with disturbing clarity" that the rates established by the Superintendent have been historically inadequate (RA. 12; Department's Report at 73-74). The rates challenged by MMIA in the proceedings below are admittedly inadequate, absent consideration of indeterminable future surcharges. Clearly, MMIA's member companies are subject to risk of substantial loss, which the Supreme Court of North Carolina held to be constitutionally impermissible. The decision of the New York Court of Appeals obviously is in conflict with the decision of the Supreme Court of North Carolina.

Other decisions upholding state statutes compelling insurer participation in joint underwriting associations uniformly require that the rates chargeable by the JUA be adequate, reasonable and not confiscatory. *See Insurers' Action Council, Inc. v. Markman*, 490 F. Supp. 921, 930 (D. Minn. 1980) (each involuntary insurer is authorized to "apply its own underwriting standards and charge a premium commensurate with the risk assumed" (citation omitted)), *aff'd*, 653 F.2d 344 (8th Cir. 1981); *State Farm Mut. Automobile Ins. Co. v. Whaland*, 121 N.H. 400, 406, 430 A.2d 174, 178-79 (1981) ("Rates are based upon actual loss experience . . . [and the insurer] is free to seek additional or increased rates, providing they are based on tangible factors that justify the levy of a higher premium."); *Sheeran v. Nationwide Mut. Ins. Co.*, 80 N.J. 548, 560, 404 A.2d 625, 631 (1979) ("[i]nability to obtain reasonable rates would, of course, justify judicial correction"). The decision of the New York Court of Appeals rejecting MMIA's claim of confiscation because MMIA is only "a creature of statute" (App. A at 13a)

manifestly conflicts with the federal constitutional restraints enforced by other state courts with respect to JUA rates.

In *Aetna Casualty & Surety Co. v. Commissioner of Insurance*, 358 Mass. 272, 263 N.E.2d 698 (1970), the Supreme Judicial Court of Massachusetts held that insurance rates that would produce an underwriting loss in a single year were confiscatory and unconstitutional:

> While it is not constitutionally required to fix rates which will guarantee a profit to all insurers, it may not constitutionally fix rates which are so low that if insurers engage in business they may do so only at a loss. The insurers are not required to either submit to confiscatory rates or go out of business. They have a right to rates which are not confiscatory . . . .

Id. at 281, 263 N.E.2d at 703.

The decision of the New York Court of Appeals upholding a scheme of inadequate rates—which has been demonstrated to result in losses to the insurer—is clearly in conflict with the decisions of courts of other states. Review by this Court to resolve the conflict among the state courts is required.

III

The Decision of the New York Court of Appeals Is Likely To Force Insurers To Divert Resources from Other States To Fund New York's Growing Medical Malpractice Deficits, Exacerbate Insurance Availability Problems and Cause Confusion and Uncertainty in the National Insurance Marketplace

The uncontroverted evidence in the record of the proceedings below indicates that the two major writers of medical malpractice insurance in New York have developed a combined operating deficit of over $3 billion.[15] The amount of the deficit

15 As a consequence of the Superintendent's refusal to approve adequate rates in prior policy years, MMIA and MLMIC, as of December

continues to accumulate under the inadequate rates that the Superintendent has established for policy year 1988-89. It will grow even larger under the rates that the Superintendent has indicated that he will establish for policy years 1989-90 and 1990-91. Just the interest on this deficit far exceeds the maximum annual assessment available under New York's Security Fund (A. 1266-68).[16]

MMIA's member companies therefore are exposed to substantial risk of assessment for the deficits accruing not only to MMIA but also to other New York medical malpractice insurers. The companies will be forced to divert capital and surplus committed to other states and other lines of insurance to fund the New York malpractice deficits. The size of the assessments are likely to force the liquidation of more insurance companies.[17] The resulting loss of insurance capacity would exacerbate

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31, 1985, had a combined deficit of $1.5 billion (A. 1004-05, 1024, 1267). The rates set by the Superintendent for policy years 1985-86, 1986-87 and 1987-88 were projected to produce a total additional combined deficit of $1.6 billion (A. 1197-98, 1221-22, 1283, 1287).

16 One projection recently made by the Department shows:

> not only a continuing "insolvency", but also that the malpractice insurers would be expected to run out of cash (assets) between the year 2000 and 2005. At that time there will be no money to pay any claims on past, current, or future incidents and a serious crisis would occur. It further shows that the deficit (negative surplus) would continue to grow so that it would exceed $10,000,000,000 before the year 1995.

Department's Report at 107.

17 Mandatory Security Fund assessments were ordered against MMIA and its members, effective May 15, 1988. N.Y. Ins. Dep't Circular Letter No. 9 (1988); *see Alliance of Am. Insurers v. Cuomo*, 854 F.2d 591, 595 (2d Cir. 1988). There have been in recent years sharp increases in the number of insurance companies placed in liquidation and in assessments against security funds. *See The Cost of Property and Casualty Insolvencies: A Special Report from the National Committee on Insurance Guaranty Funds*, in Nat'l Inst. on Insurer Insolvency, ABA Section of Tort & Ins. Practice, *Reference Handbook on Insurance Company Insolvency* 46 (1986).

problems of insurance availability for important forms of risk, which exist in virtually all states.[18]

The decision of the New York Court of Appeals also has introduced great uncertainty in the insurance marketplace. Many insurers do business in several states. Where required, these insurers participate in state-created JUA's in order to satisfy the conditions of doing business in those states. Prior to the decision of the New York Court of Appeals, the insurers could undertake the business of insurance in a state with the assurance that the state could not unfairly compel it to subsidize artificially-restrained insurance costs for a special class of insureds. No longer can that assumption safely be made. Moreover, since the 1986 Act imposed inadequate rates on MMIA retroactively to July 1, 1985, insurers may even be subject to unlimited liabilities through mandated participation in JUA's in states where their resources are already committed.

The scheme of rates upheld by the New York Court of Appeals likely will be adopted by other states to provide coverage for particular classes of risk where insurance otherwise is unavailable or unaffordable. States thereby may benefit their local citizens at the expense of insurance availability on a nationwide basis.

The decision of the New York Court of Appeals also upheld a statutory scheme of "cash-flow" underwriting, which generally has not been permissible under state insurance laws. Cash-flow underwriting greatly increases the risk of insurer insolvencies. Insurance companies can operate on a sound basis only where liabilities are offset by current assets.

> The only way the insurance business can be conducted soundly on an advance premium basis is by providing for the obligations contracted to be met in the future. As we

18 *See* State of N.Y., Governor's Advisory Comm'n on Liab. Ins., *Insuring Our Future* 23-24 (1986). Examples of the most frequently cited "uninsurable" risks include pollution-producing activities, recreational activities, some forms of mass transportation, activities of directors and officers, and child care centers. *Id.*

> have seen, this is done by setting up the present value of these obligations as liabilities. . . .
>
> . . . .
>
> The critical importance of the reserves in the financial stability and solvency of a company is apparent when we recognize that the reserves are true liabilities. Although it is common to think of a reserve as a fund set aside to meet expected or unexpected contingencies, as we have already seen, the reserves we speak of in insurance are true liabilities. They are a true actuarial measurement of the company's liabilities to its policyholders and claimants that must be offset by assets.

E. Vaughan & C. Elliott, *Fundamentals of Risk and Insurance* 141 (2d ed. 1978).

The decision of the New York Court of Appeals condoned a financially disastrous regulatory scheme with broad ramifications for the nationwide liability insurance market. Removing state-created, but privately funded, insurance entities like MMIA from the protections of the fifth and fourteenth amendments will have a disruptive effect on the entire casualty insurance industry. Review by this Court is necessary and warranted.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that this petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A

Opinion and Judgment of the Court of Appeals of the State of New York

STATE OF NEW YORK
COURT OF APPEALS

Argued November 16, 1988 Decided December 15, 1988

IN THE MATTER OF MEDICAL MALPRACTICE INSURANCE ASSOCIATION,

Respondent,

v.

SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,

Appellant.

Robert Abrams, Attorney General (Richard G. Liskov, O. Peter Sherwood, Lawrence S. Kahn of counsel), for appellant.

T. Richard Kennedy, Larry P. Schiffer, Michael A. Knoerzer, for respondent.

OPINION OF THE COURT

TITONE, J.

In response to the continuing upward spiral of medical malpractice liability insurance, the Legislature, in 1985 and again in 1986, passed substantive and procedural rules designed to

restrain increases in medical and dental malpractice premiums (*see*, L 1985, ch 294; L 1986, ch 266). The underlying legislative concern was that increasing malpractice premiums threaten the public health by discouraging physicians from initiating or continuing the practice of medicine in New York. The legislative reforms have been challenged on many fronts (*see, Medical Malpractice Ins. Assn. v Cuomo*, 138 AD2d 177, *lv granted* 143 AD2d 548; *Alliance of Am. Insurers v Cuomo*, 854 F2d 591). This article 78 proceeding involves one discrete aspect of the Medical Malpractice Reform Act of 1986 (L 1986, ch 266).

Specifically, petitioner challenges the premium rates set by the respondent, Superintendent of Insurance, pursuant to section 40 of the temporary insurance rate-stabilization program (L 1986, ch 266, § 40). The issue presented is whether the primary and excess premium rates established by the Superintendent pursuant to section 40 are inconsistent with other statutory requirements (*see*, Insurance Law §§ 5505, 2303) and thus arbitrary and capricious. We hold that the Superintendent's interpretation of section 40 was reasonable, that the rates set in reliance on this interpretation were not arbitrary or capricious, and that petitioner's alleged claim of confiscation does not lie. Accordingly, we reverse the order of the Appellate Division which affirmed the Supreme Court judgment annulling the Superintendent's determination, and reinstate that determination.

I.

Petitioner, the Medical Malpractice Insurance Association (MMIA), is a nonprofit unincorporated association which was created by the Legislature in 1975 in response to the withdrawal of many private insurance companies from the medical malpractice market in New York. MMIA was created for the express purpose of providing medical malpractice insurance, which is no longer readily available in the voluntary market (L 1975, ch 109, § 17; *see*, Insurance Law § 5502[c], [d]. MMIA is required to provide primary medical malpractice

insurance to physician applicants with policy limits of $1 million per claim, and an annual aggregate limit of $3 million (Insurance Law § 5502 [e] [1]). In 1985, the Legislature mandated that MMIA provide excess coverage of at least $1 million per claim, and $3 million for all claims in any one policy year (L 1985, ch 294, § 17). Since 1975, the Superintendent has set premium rates pursuant to provisions of the Insurance Law requiring the lowest possible rates consistent with the maintenance of MMIA's solvency, and the establishment of reasonable reserves and surpluses (Insurance Law § 5505 [a], [b]; *see also*, Insurance Law § 2303).

From 1980 to 1985, MMIA's rate increased by over 200%. To alleviate this critical problem, in 1985 and 1986, the Legislature implemented various changes in the prosecution of medical malpractice liability cases (L 1985, ch 294; L 1986, chs 266, 682). Significant changes were made in payment of damages, attorneys' fees, pretrial discovery, and the application of joint and several liability for noneconomic losses (*see generally*, Note, *New York's Medical Malpractice Insurance Crises—A New Direction for Reform*, 14 Fordham Urban LJ 773[1986]).

A hearing on the rates to be established for 1985-1986 was held before a Special Deputy Superintendent (SDS). Following extensive hearings, the SDS found that MMIA was entitled to an 86.7% increase in physician and surgeon rates. However, before recommendations could be implemented, the Governor signed the Medical Malpractice Reform Act of 1986 (L 1986, ch 266). Pursuant to section 40 of this Act, the Superintendent was directed to establish rates for each policy year commencing July 1, 1985 through June 30, 1988. In addition, section 40 authorized the Superintendent, commencing July 1, 1989, to impose an annual surcharge of up to 8%, if needed, to satisfy any actuarially projected deficiency resulting from the rates that he had established for each of the 1985-1988 policy years (L 1986, ch 266, § 40). Section 40 provides that the surcharges shall be deemed income earned for the purposes of Insurance Law

§ 2303 which requires that premium rates be calculated in such a way as to maintain solvency.[1]

Relying on section 40, the Superintendent promulgated the Sixth, Seventh, Eighth and Tenth Amendments to Regulation No. 101 (11 NYCRR 70.8) establishing primary and excess premium increases for 1985-1986, 1986-1987, and 1987-1988. The allowed increases have been established as follows:[2]

	Primary Rate	Excess Rate	
		1st Layer	2nd Layer
1985-1986	14%	30%	30%
1986-1987	9%	35%	24%
1987-1988	9%	40%	28%

The Superintendent has not yet established a surcharge rate, since, under section 40, such a determination can only be calculated after any deficiency arising from the prior years is deter-

1. Section 40 provides in pertinent part that: "The superintendent of insurance shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred eighty-eight. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July first, nineteen hundred eighty-nine, the superintendent shall impose a surcharge on premiums to satisfy any actuarially projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the approved adequate rate and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency * * * The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law" (L 1986, ch 266, § 40).

2. When this action was initiated only the Sixth and Seventh Amendments had been passed, and thus only these amendments were challenged. However, the parties have agreed by stipulation to allow petitioner to supplement its petition and challenge the provisions of the Eighth and Tenth Amendments.

mined. However, in order to facilitate the calculation of deficiencies arising from the three policy periods, and the corresponding future surcharge needed to offset the prior deficiencies, the Superintendent directed the establishment of segregated accounts for premium payments, reserves and investment income attributable to each of the policy periods. Critically, in setting these rates, the Superintendent concededly considered that a surcharge of up to 8% could be imposed in the future. Both parties agree that without this consideration of future surcharges, both the primary and the two excess layers of insurance are entirely inadequate to meet the statutory standards of solvency under the Insurance Law (*see*, Insurance Law §§ 5505, 2303).

MMIA brought the present article 78 proceeding to challenge the Superintendent's approach, contending that his interpretation of section 40 is unreasonable, and has resulted in rates which are not actuarially sound, self-supporting, based upon reasonable standards or consistent with statutory standards of solvency. MMIA also claims that the rates are confiscatory and will result in an unconstitutional taking of property in violation of the State and Federal Constitutions (US Const 5th, 14th Amends; NY Const, art I, §§ 6, 7).

Implementation of the rates was stayed on August 12, 1986, and the parties agreed by stipulations to interim primary and excess rates for the 1985-1988 policy years pending exhaustion of all appeals in this proceeding. The issues raised in the proceeding were then submitted to a Referee, who agreed with the Superintendent that future surcharges should be considered in fixing present rates, and concluded that the Superintendent, in setting the 1985-1988 primary rates, properly relied upon actuarial figures derived, in part, from the original figures supplied by the SDS. However, concerning the excess rates, the Referee recommended a remand to the Superintendent for further explanation since he found the record before him to be insufficient.

Supreme Court rejected the Referee's report and set aside the determination of the Superintendent. The court disagreed with

the Superintendent's interpretation of section 40, reasoning that the language directing insurers to establish segregated accounts for the 1985-1988 policy years expressed a "legislative hope that the rates to be set would be sufficient, under the existing circumstances of general uncertainty in the malpractice insurance field", without any surcharge at all (137 Misc 2d 785, 791). The court ruled that future surcharges were not even to be considered by the Superintendent, "until his monitoring of the accounts toward the end of the 1985-1988 period established a necessity for that action" (*id.*). The Superintendent's interpretation was found to be at odds with the "self-supporting" requirement for rates contained in section 5505 (Insurance Law § 5505). The court also rejected the Referee's findings that the rates established would not impermissibly impair the solvency of MMIA, and questioned the constitutionality of section 40. Finally, the court gave short shrift to the Superintendent's actuarial calculations concerning future rate structure. The court simply classified the figures as "scenarios", and concluded they were insufficient. A divided Appellate Division affirmed on Supreme Court's opinion, the dissenting Justices agreeing with the Superintendent's interpretation of section 40, particularly in view of its provision treating surcharges as earned income for the purposes of section 2303 (*see*, Insurance Law § 2303 [requiring that all earned income be included in determining whether the rates comply with the statutory requirements of solvency]).[3]

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3. Following the Appellate Division's affirmance, section 40 was amended as follows: "Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates" (L 1988, ch 184, § 19).

The amendment was made retroactive to July 8, 1986, the day before the rates challenged in this proceeding were initially promulgated (L 1988, ch

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II.

At issue in this appeal is whether the Superintendent's consideration of future surcharges in the fixing of present rates was consistent with section 40, and the statutory requirements of solvency set forth in sections 2303 and 5505 of the Insurance law. Section 5505 (b) of the Insurance Law, which governs MMIA, provides in pertinent part: "All rates shall be on an actuarially sound basis, be calculated to be self-supporting, be based upon reasonable standards * * * The premiums shall be fixed at the lowest possible rates consistent with the maintenance of solvency of the association and of reasonable reserves and surplus therefor." Section 2303 provides that the "[r]ates shall not be * * * detrimental to the solvency of insurers." As the parties agree, without the consideration of future surcharges in determining present rates, the rates set by the Superintendent would be inadequate and would not satisfy the statutory requirements of solvency.

In reviewing the Superintendent's interpretation of his legislative authorization in section 40, we defer to his special expertise and views, unless the interpretation is irrational or runs counter to the clear wording of the statutory provision (*see, New York Pub. Interest Research Group v Town of Islip*, 71 NY2d 292, 303; *Matter of New York Pub. Interest Research Group v New York State Dept. of Ins.*, 66 NY2d 444, 448;

184, § 22). In addition, other amendments extend the Superintendent's authority to establish rates pursuant to section 40 through June 30, 1991, and increases the maximum surcharge to 25%, beginning in the 1991-1992 policy year, and continuing until any deficiencies have been recouped (L 1988, ch 184, § 19; ch 186).

After these enactments, respondent sought to renew and/or reargue before the Appellate Division. The court granted renewal but adhered to its original decision, the same two Justices again dissenting. By stipulation, both the appeal from the original decision, and the appeal from the order adhering to that decision, have been consolidated. Since we conclude that the Superintendent's original interpretation of the unamended version of section 40 was proper, we need not address the effects, if any, of the subsequent amendments.

Kurcsics v Merchants Mut. Ins. Co., 49 NY2d 451, 459; *Ostrer v Schenck*, 41 NY2d 782, 785). We conclude from the statute and its history that the Superintendent's interpretation of the statute is reasonable and should be sustained.

The Superintendent's position is based upon the last sentence of section 40, which provides: "The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law." He also relies on Insurance Law § 2303, which provides that "[i]n determining whether rates comply with the foregoing standards, the superintendent shall include all income earned by such insurer". Construing these provisions together, the Superintendent concluded that the anticipated future surcharges, which are designated as income earned, should be considered both in determining present rates and in calculating the solvency of MMIA as required by sections 2303 and 5505. This view of the statutory language is reasonable. If future surcharges were not to be accounted for until actually received beginning in 1989, then the last sentence of section 40 would be superfluous, since moneys actually received would undoubtedly be deemed income earned at that time. Thus, the Legislature must have intended that the future surcharges be considered on an accrual basis similar to the treatment of investment income (*see generally*, McKinney's Cons Laws of NY, Book 1, Statutes §§ 92, 94).

Further, the legislative history is clear. Governor Cuomo noted in his approval memorandum that "the bill authorizes the Superintendent of Insurance to establish rates for a three-year period (July, 1985-June, 1988) that will provide a measure of badly needed premium stability as these reforms begin to take hold. *In establishing these premium levels, the Superintendent is authorized to consider the availability of surcharges in future years that could be imposed*, beginning in 1989, to restore any potential deficiency created during the premium stabilization period" (1986 NY Legis Ann, at 161 [emphasis added]).

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It is clear that temporary rate stabilization is designed to complement the numerous remedial measures codified in 1985 and 1986 (L 1985, ch 294; L 1986, ch 266). Section 40 is designed to bridge the gap and allow the other reforms to start taking effect. Further, as pointed out by the dissenting Justices, if petitioner's interpretation of section 40 is correct, section 40 would mean nothing and do nothing. If the Superintendent cannot account for future surcharges in calculating present rates, then the current rate increase would have to be approximately 86.7%—the rate recommended by the SDS. Nothing in chapter 266 reveals that the Legislature intended such extraordinary increases in premiums from 1985 through 1988. To the contrary, as chapter 266, section 1, plainly states, the purpose of the chapter is to "reduce the cost of [medical] malpractice insurance * * * [and] significantly reduce physician and health care system costs in the short-run" (L 1986, ch 266, § 1), during which time the positive actuarial effects of the prophylactic measures in the 1985 and 1986 legislation can begin to serve their purpose.

Thus, we conclude that the Superintendent correctly interpreted section 40 by considering future surcharges.

III.

We next consider whether the Superintendent's reliance upon his actuary's calculations was arbitrary or capricious (*see*, CPLR 7803 [3]; *Matter of Colton v Berman*, 21 NY2d 322; *Matter of Schwartz v Corcoran*, 118 AD2d 355, 361). Supreme Court gave short shift to respondent's actuarial data, simply labeling them as "scenarios", and concluding that the rates were not set on an actuarial basis as required by Insurance Law § 5505 (b). However, as the Referee found, actuarial data existed, and the Superintendent's rate decisions were based on such data. It is axiomatic that a court reviewing the determination of an agency may not substitute its judgment for that of the agency and must confine itself to resolving whether the determination was rationally based (*see, Matter of Procaccino v. Stew-*

art, 25 NY2d 301). We conclude that in annulling the Superintendent's determination the courts below exceeded their review powers.

Throughout the course of this litigation, the parties' actuaries have disagreed on almost everything. Just as they disagree concerning the impact of the surcharge on future deficits, the actuaries also disagree about the potential beneficial impact of the 1985 and 1986 reform legislation. A disagreement among actuaries, however, is not evidence that the Superintendent's acceptance of one set of conclusions was arbitrary (*see, Matter of New York State Council of Retail Merchants v Public Serv. Commn.*, 45 NY2d 661, 672-674; *Montgomery v Daniels*, 38 NY2d 41, 53).

Respondent's actuarial projection used the SDS's 86.7% suggested rate increase as a starting point. The purpose of this calculation was to determine whether an 8% surcharge to future premiums, commencing with the policy year 1989-1990, would ultimately offset deficiencies arising from the curtailed rates set for policy years 1985-1988. Based on the Superintendent's calculations, it was shown that the deficit caused by the 1985-1988 rates could be cured by approximately the year 2000. While the computation was founded upon numerous assumptions, including future interest rates, projected decreases in severity of claims due to accompanying legislative reforms,[4] and the Superintendent's willingness to permit "adequate" increases beginning in 1988-1989 and the following years, the use of such

4. Severity refers to the amount of losses on such claims. Importantly, section 5505 (a) provides that MMIA's rates shall give "due consideration to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this state, trends in the frequency and severity of losses, the investment income of the association, and such other information as the superintendent may require." (Insurance Law § 5505 [a].) Thus, section 5505 (a) instructs the Superintendent to extrapolate upon trends in medical malpractice insurance. It cannot be deemed unreasonable, as a matter of law, to consider the potential beneficial impact of the accompanying reforms on the severity of future claims.

assumptions does not render the Superintendent's conclusions irrational.

As to the rates for layers of excess coverage, the Referee concluded that the record as to how the rates for excess policies were calculated was not complete, and thus recommended remitting this question to the Superintendent for further explanation. We disagree (*see, Matter of Colton v Berman*, 21 NY2d 322, 334, *supra*).

As he has consistently done in the past, the Superintendent fixed over-all rates for excess layers as percentages of the rates approved for primary coverage. In addition, the Superintendent's actuarial witness testified that while excess programs at inadequate rates would increase the deficit, there would be greater surcharge income in future years, and that the two would offset each other. This alone should have been sufficient (*see, Matter of Procaccino v Stewart*, 25 NY2d 301, *supra*). Moreover, this court can take judicial notice of the Regulatory Impact Statement (*see*, CPLR 4511 [b], [c]) which the Superintendent filed in connection with the Ninth Amendment to Regulation No. 101 while this case was pending before the Supreme Court (*see*, 11 NYCRR 70.8). This statement explains how the same factors used by the actuaries in setting primary rates were also used in setting excess rates, and consequently supplies an adequate rational basis for the excess rates (*see*, New York State Register, May 6, 1987, at 10-11; *see also*, CPLR 7803; *Matter of Colton v Berman*, 21 NY2d 322, *supra*).

IV.

Accepting the Superintendent's interpretation of section 40 and his actuarial projections, it is apparent that MMIA may well be forced to run at a deficit until the surcharges result in recoupment in approximately the year 2000. Petitioner argues that requiring MMIA to run a continued deficit for this length of time proves that the Superintendent's decision is arbitrary and capricious, and, alternatively, results in a confiscation of property in violation of the Fifth and Fourteenth Amendments

of the United States Constitution (US Const 5th, 14th Amends) and article I, sections 6 and 7 of the New York State Constitution (NY Const, art I §§ 6, 7).

According to the express language of section 40, there is no time limit within which the deficits must be made up. Section 40 merely provides that the 8% surcharge "shall continue for such period of time as shall be sufficient to satisfy such deficiency" (L 1986, ch 266, § 40). As previously noted, the deficit attributable to the diminished rates for 1985-1988 on primary and excess policies will be recouped by about the year 2000. This 15-year period for recoupment is not unreasonable, since according to respondent's chief actuary, the established rates coupled with the 8% surcharge after 1989, will enable MMIA to remain liquid and pay claims as they come due, at least through the year 2010. More importantly, medical malpractice claims are "long-tailed", so that claims made on policies written between 1985 to 1988 will not, on average, be payable until after 1995-1998. Thus, it is entirely conceivable that the deficit will be made up while some losses attributable to policies written and premiums collected in 1985-1988 are still unpaid.[5] The combination of the "long-tailed" nature medical malpractice claims along with the other statutory reforms promulgated under the 1985 and 1986 acts makes the long-term deficit entirely reasonable. If the reforms have their expected salutary effect, the collection of unnecessarily high premiums will be avoided. If the reforms are not as successful as expected, the surcharge provides a sensible method of meeting any deficiency that may develop over the long period within which claims mature.

Finally, we reject MMIA's claim that section 40 is confiscatory as to it. MMIA was created by the Legislature of the State of New York in order to provide much needed medical malprac-

5. In its Regulatory Impact Statement, the Superintendent points out that the average payout time for excess claims is significantly greater than 10 years. "Since many excess losses for policies written in policy years 1985/86 and 1986/87 will not be payable until beyond the year 2000, the excess deficit will be made up while some losses attributable to excess policies written during policy years 1985/86 and 1986/87 remain unpaid" (New York State Register, May 6, 1987, at 11).

tice insurance. MMIA is a creature of statute, and all of its rights, obligations and duties have been defined by the Legislature (*see*, Insurance Law art 55). MMIA may operate only for fixed periods of time and only if the Superintendent determines that medical malpractice insurance is not readily available in the voluntary market (Insurance Law § 5505 [d]). In addition, MMIA's operations are subject to the Superintendent's extensive and direct control (Insurance Law § 5503 [c]). Importantly, although all insurance companies writing personal injury insurance in New York are required to be members of MMIA as a condition of transacting business in this State (Insurance Law § 5502 [a]), MMIA is a nonprofit unincorporated association which is a legal entity separate and distinct from its members (Insurance Law § 5502 [b]). Moreover, all funds and reserves of MMIA are held and invested separately from its members (*id.*).

Thus, as a statutory entity created by the Legislature, the State's broad police power can be implemented to foster affordable medical malpractice coverage, with the possibility that MMIA will operate under a deficit. Indeed, such deficits were expressly contemplated in the enabling legislation (Insurance Law § 5507, 5509). In this regard, even if MMIA will operate at a continued loss, such a loss is not confiscatory vis-à-vis MMIA (*see, Brooks-Scanlon Co. v Railroad Commn.*, 251 US 396, 399 ["It is true that if a railroad continues to exercise the power conferred upon it by a charter from a State, the State may require it to fulfil an obligation imposed by the charter, even though fulfilment in that particular may cause a loss."]; *Missouri Pac. Ry. Co. v Kansas*, 216 US 262, 276, 278; *Atlantic Coast Line v North Carolina Corp. Commn.*, 206 US 1). Since the individual insurance companies which are members of MMIA and are required to make up any deficit which may be incurred by MMIA (Insurance Law § 5507 [b])[6] are not parties

6. MMIA, from its very inception, has been required to maintain a stabilization reserve fund for the purpose of offsetting deficits and "for reimbursement to the association's members for payment of any deficit arising out of the operations of the association" (Insurance Law § 5509 [a]). While

to this proceeding, we do not consider the degree to which the Superintendent's regulations, or the underlying statutory scheme, may be confiscatory as to them (*see, Alliance of Am. Insurers v Cuomo*, 854 F2d 591, *supra*).

Accordingly, the order of the Appellate Division should be reversed, with costs, the petition dismissed and the determination of the Superintendent of Insurance reinstated.

Chief Judge WACHTLER and Judges SIMONS, KAYE, ALEXANDER, HANCOCK, JR., and BELLACOSA concur.

Order reversed, etc.

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recent legislation has been passed affecting the stabilization fund (L 1986, ch 266, § 11), MMIA has not raised any claims concerning the stabilization fund in this action (*see, Medical Malpractice Ins. Assn. v Cuomo*, 138 AD2d 177, *lv granted* 143 AD2d 548).

Appendix A

Remittitur

COURT OF APPEALS
STATE OF NEW YORK

The Hon. Sol Wachtler, Chief Judge, Presiding

1 No. 331

In the Matter of Medical Malpractice Insurance Association,
Respondent,

v.

Superintendent of Insurance of the State of New York,
Appellant.

The appellant in the above entitled appeal appeared by Hon. Robert Abrams, Attorney General of the State of New York; *the respondent appeared by* Werner Kennedy & French, Esqs.

The Court, after due deliberation, orders and adjudges that the order is reversed, with costs, petition dismissed and determination of the Superintendent of Insurance reinstated. Opinion by Judge Titone. Chief Judge Wachtler and Judges Simons, Kaye, Alexander, Hancock and Bellacosa concur.

The Court further orders that the papers required to be filed and this record of the proceedings in this Court be remitted to the Supreme Court, New York County *there to be proceeded upon according to law.*

I certify that the preceding contains a correct record of the proceedings in this appeal in the Court of Appeals and that the papers required to be filed are attached.

/s/ DONALD M. SHERAW
Donald M. Sheraw, Clerk of the Court

Court of Appeals, Clerk's Office, Albany, December 15, 1988

APPENDIX B

Memorandum Opinion of the Supreme Court of the State of New York, Appellate Division, First Department

SUPREME COURT OF THE STATE OF NEW YORK,
APPELLATE DIVISION, FIRST DEPARTMENT

Decided September 20, 1988

In the Matter of MEDICAL MALPRACTICE INSURANCE ASSOCIATION v SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK.—Motion (1) granted only insofar as to permit renewal and, upon renewal, this court adheres to the determination in its order [141 AD2d 475], and (2) denied wherein it seeks reargument. Kupferman, J. P., Sullivan and Kassal, JJ., concur; Asch and Rosenberger, JJ., dissent.

APPENDIX C

Memorandum Opinion of the Supreme Court of the State of New York, Appellate Division, First Department

SUPREME COURT OF THE STATE OF NEW YORK,
APPELLATE DIVISION, FIRST DEPARTMENT

Decided June 30, 1988

In the Matter of MEDICAL MALPRACTICE INSURANCE ASSOCIATION, Respondent, v SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK, Appellant.—Judgment, Supreme Court, New York County (Martin Evans, J.), entered on October 21, 1987, affirmed for the reasons stated by Martin Evans, J., without costs and without disbursements. Concur—Kupferman, J. P., Sullivan and Kassal, JJ.

Asch and Rosenberger, JJ., dissent in the following memorandum by Asch, J. In rejecting the determination of the Superintendent of Insurance, the majority rejects the labors of successive Legislatures, two Governors of the State of New York, representatives of the public and the medical profession, all of whom have struggled to fashion a solution for the awesome problem of accelerating medical malpractice insurance costs. The result of their efforts, in my opinion, is a feasible plan to restrain such insurance rates, a plan which is clearly supported by statute and principles of constitutional law. Accordingly, I would reverse the judgment and order which granted petitioner's CPLR article 78 petition and annulled the Superintendent's determination as set forth in Regulation No. 101 (11 NYCRR 70.8) and the amendments thereto.

The Legislature, with former Governor Carey, enacted, in 1975, current article 55 of the Insurance Law, enabling peti-

tioner Medical Malpractice Insurance Association (Association) to act as a nonprofit joint underwriting association of insurers. Under this legislation, the Association is to provide coverage at the lowest possible rates consistent with solvency and reasonable rates and surplus (Insurance Law § 5505).

The rates, however, continued to spiral upward, prompting modification by the Legislature of substantive and procedural rules relating to medical malpractice suits (*see*, L 1985, ch 294; L 1986, ch 266). The Medical Malpractice Reform Act of 1986 (L 1986, ch 266) amended the CPLR, Insurance Law, Public Health Law and other statutes, declaring:

"Section 1. Legislative findings and declaration. The legislature hereby finds and declares that reforms have been enacted to restrain increases in medical and dental malpractice premiums and related costs and to prevent medical and dental malpractice * * *

"In the meantime, the legislature finds and declares that upward pressures on already high malpractice premiums continue to threaten the public health by discouraging physicians and dentists from initiating or continuing their practice in New York and by contributing to the rising cost of health care as premium costs are passed along to health care consumers.

"The legislature finds and declares, therefore, that additional steps must be taken in the public interest to reduce the cost of malpractice insurance, such as providing the superintendent of insurance with the authority to establish rates for medical malpractice insurance and gradually requiring the issuance of only claims-made policies which will significantly reduce physician and health care system costs in the short-run and substantially enhance the reliability and predictability of malpractice insurance rate regulation in the future."

Governor Cuomo, who had participated very vigorously in seeking a solution to the problem, approved the legislation and in strong language endorsed the modus operandi for keeping down malpractice insurance rates. In his approval memorandum (1986 NY Legis Ann, at 161), he said, in part: "The bill focuses, moreover, on the insurance system itself. The previ-

ously enacted reform of the State's regulatory authority over liability insurance is complemented by provisions in this bill that gradually require the transition to 'claims-made' coverage, which will permit significantly lower premiums in the short run as well as greater actuarial certainty and predictability. In addition, the bill authorizes the Superintendent of Insurance to establish rates for a three-year period (July, 1985-June, 1988) that will provide a measure of badly needed premium stability as these reforms begin to take hold. In establishing these premium levels, the Superintendent is authorized to consider the availability of surcharges in future years that could be imposed, beginning in 1989, to restore any potential deficiency created during the premium stabilization period. The bill also continues to provide hospital-affiliated physicians with an additional one million dollars of protection to cover claims in excess of affordable insurance coverage—and provides this coverage in a manner that protects hospitals from a financial burden that they cannot fairly assume."

In an attempt to "significantly reduce physician and health care system costs in the short-run", the avowed purpose of the legislation, section 40 of Laws of 1986 (ch 266) provided: "§ 40. The superintendent of insurance shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred eighty-eight. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July first, nineteen hundred eighty-nine, the superintendent shall impose a surcharge on premiums to satisfy an actuarially projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the approved adequate rate

and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency * * * Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law."

In accordance with this legislation and faced with a pending request for a rate increase (and a recommendation by Honorable Matthew J. Jasen as Special Deputy Superintendent-Hearing Officer for, *inter alia*, an 86.7% increase in primary insurance premium rates for 1985-1986 over 1984-1985), the Superintendent promulgated the Sixth Amendment to Regulation No. 101 (11 NYCRR 70.8) establishing primary rates for such insurance of 14% for the 1985-1986 policy year and 9% for the 1986-1987 policy year. The Seventh Amendment additionally established excess rate levels for the 1985-1986 and 1986-1987 policy years.

Although he did not establish a surcharge percentage to be imposed starting in 1988-1989 (since such imposition must await a determination of the deficiency arising in prior years), the Superintendent directed the establishment of segregated accounts for premium reserves and investment income for each of the policy periods, so that deficiencies arising from each period and the amount of surcharges necessary could be ascertained more readily.

The petitioner Association brought this proceeding challenging the rates fixed by the Superintendent in Regulation No. 101. It contended the rates were inadequate and did not meet the statutory standards set in Insurance Law §§ 5505 and 2303 in that, *inter alia*, they are not actuarially sound, are not calculated to be self-supporting or based upon reasonable standards,

are not consistent with the maintenance of reasonable reserves and surplus and, additionally, that the Superintendent's action in fixing the rates for 1985 through 1988 was arbitrary and capricious and without rational basis.

The Supreme Court referred the matter to Honorable Samuel J. Silverman to hear and report on the issues. In a detailed and comprehensive report, Justice Silverman agreed with the respondent that section 40 of Laws of 1986 (ch 266) authorized the consideration of the future surcharges in fixing rates for the July 1, 1985 to June 30, 1988 period. He further found that the primary rates fixed by the Superintendent in reliance upon his actuary's calculations were not arbitrary or capricious or without rational basis. As for the rates for excess policies, he recommended a remand for further explanation by the Superintendent since the record before him was insufficient. The Supreme Court rejected this report and set aside the determination of the Superintendent fixing the rates in Regulation No. 101, directing the Superintendent to fix the 1985-1988 rates in accordance with the Insurance Law. The majority of this court agrees with that judgment. I do not and would reverse, confirming Justice Silverman's report and denying the relief requested in the petition with respect to the primary rates for 1985-1988.

Petitioner, as indeed the nisi prius court, relies mainly on the provisions of the Insurance Law predating the enactment of section 40. Thus, section 5505 of the Insurance Law, which relates specifically to the petitioner, provides in pertinent part:

"§ 5505. Rates

"(a) The rates, rating plans, rating rules, rating classifications, territories and statistics applicable to the insurance written by the association shall be subject to article twenty-three of this chapter, giving due consideration to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this state, trends in the frequency and severity of losses, the investment income of the association, and such other information as the superintendent may require.

Appendix C

"(b) All rates shall be on an actuarially sound basis, be calculated to be self-supporting, be based upon reasonable standards * * * The premiums shall be fixed at the lowest possible rates consistent with the maintenance of solvency of the association and of reasonable reserves and surplus therefor."
Section 2303 of the Insurance Law provides: "§ 2303. Standards for rates. Rates shall not be excessive, inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of insurers. In determining whether rates comply with the foregoing standards, the superintendent shall include all income earned by such insurer and any insurer controlling or controlled by such insurer or under common control by or with such insurer on all its investments of any kind and wherever located."

As the Referee found, the primary insurance rates as fixed by the Superintendent *without* the imposition of any surcharges are inadequate and would not meet the statutory standards set out above.

However, section 40 of Laws of 1986 (ch 266) expressly authorized the Superintendent to set the rates for the 1985-1988 policy years at levels *below* those authorized solely by consideration of the prior statutory criteria *and to make up any ongoing deficit by calculating and including the anticipated surcharges.* Thus, section 40 explicitly provides: "The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law." Section 2303 provides, *inter alia*: "In determining whether rates comply with the foregoing standards, the superintendent shall include all income earned by such insurer". Thus, the surcharges were correctly utilized by the Superintendent to determine income when he set the rates for the 1985-1988 period.

Further, section 40 provides that the purpose of the surcharges is to satisfy deficiencies "attributable to the premium levels established pursuant to this section for such periods" (i.e., July 1, 1985 to June 30, 1988). It also provides for allocation of amounts collected on the surcharge among insurers

based on the extent of coverage provided during the 1985-1988 period. These provisions only make sense, as noted by the Referee in his report, if the rates for which the surcharges are considered income are the rates for the period 1985-1988.

Section 5505(b) requires rates set by the Superintendent for petitioner to be self-supporting but also fixed "at the lowest possible rates consistent with the maintenance of solvency of the association and of reasonable reserves and surplus therefor". The inclusion of the surcharge income, which is expressly sanctioned by the Legislature, fulfills this purpose of achieving the lowest possible rates together with insuring that the solvency of the Association is maintained. In this regard, respondent's chief actuary testified that in his opinion, on the basis of the rates established and with the 8% surcharge after 1989, the petitioner will have sufficient cash to meet its obligations as they mature at least through the year 2010, i.e., *beyond* the years at which the deficit for 1985-1988 would have been made up.

With this interpretation, section 40 of Laws of 1986 (ch 266) and sections 2303 and 5505, the preexisting statutes, are harmonized and all of the respective provisions effectuated (*see*, *Matter of Guardian Life Ins. Co. v Chapman*, 302 NY 226, 231). Accepting petitioner's interpretation, section 40 means nothing and does nothing and the plain intent of the Legislature and Governor are disregarded. (*See*, L 1986, ch 266, § 1; Governor's approval mem, *op. cit.*, at 161.)

We have previously noted in another matter involving the Superintendent's implementation of the Insurance Law: "Special Term substituted its judgment for that of the Superintendent. It was without authority to do so (*Matter of Procaccino v Stewart*, 25 NY2d 301). The Superintendent is vested by the statute with broad power and responsibility to implement the Insurance Law (*Matter of New York Public Interest Research Group v New York State Dept. of Ins.*, 66 NY2d 444; *Ostrer v Schenck*, 41 NY2d 782). As these and other cases hold, a determination of the Superintendent is to be upheld by the courts unless it lacks a rational basis (*Matter of*

American Tr. Ins. Co. v Corcoran, 105 AD2d 30, *affd* 65 NY2d 828)." (*Matter of Schwartz v Corcoran*, 118 AD2d 355, 361.)

It hardly seems necessary to address the constitutional arguments advanced by respondent. The history of the efforts by Legislatures and Governors to solve this problem, the factual record before the Superintendent, the applicable legal standards for judging the constitutional claim, long-standing decisions of the Court of Appeals and Federal appellate courts, including the Supreme Court, that rejected similar constitutional attacks on legislation which States employ to regulate insurance under their police power within constitutional constraints, make such contentions nugatory. (*See*, dissent in *Medical Malpractice Ins. Assn. v Cuomo*, 138 AD2d 177, 187.)

As found by the Referee, the Regulation adopted by the Superintendent dealing with the primary rates for the 1985-1988 period had a rational basis and was not arbitrary or capricious. [*See*, 137 Misc 2d 785.]

APPENDIX D

Opinion of the Supreme Court of the State of New York, County of New York

SUPREME COURT OF THE STATE OF NEW YORK,
COUNTY OF NEW YORK

Decided October 9, 1987

IN THE MATTER OF MEDICAL MALPRACTICE INSURANCE ASSOCIATION,

Petitioner,

v.

SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,

Respondent.

APPEARANCES OF COUNSEL

Werner, Kennedy & French (T. Richard Kennedy and *Larry P. Schiffer* of counsel), for petitioner. *Robert Abrams, Attorney-General (Jane Breslin Jacobs* and *Frank J. Wenick* of counsel), for respondent.

Appendix D

OPINION OF THE COURT

MARTIN EVANS, J.

In this proceeding under CPLR article 78, petitioner seeks judgment annulling the determination of the respondent Superintendent of Insurance which established both primary and two levels of excess premium rates for physicians' and surgeons' professional liability insurance for two policy years: July 1, 1985 through June 30, 1986 and July 1, 1986 through June 30, 1987. By amendment of the petition, petitioner also seeks the same judgment with respect to the policy year July 1, 1987 through June 30, 1988.

Petitioner Medical Malpractice Insurance Association (MMIA) alleges that the determination made by respondent was arbitrary and capricious; that it was the result of abuse of discretion; that it was made in violation of lawful procedure; that it is in violation of the 5th and 14th Amendments of the US Constitution and that it violates sections 6 and 7 of article I of the NY Constitution.

Petitioner also seeks judgment compelling respondent to establish proper premium rates for those three policy years, in compliance with the Insurance Law.

Petitioner is a nonprofit unincorporated association, first established by the Legislature in 1975 to provide medical malpractice insurance. The members of petitioner at any one time are all the insurance companies which at that time underwrite personal injury liability insurance in the State of New York, and one of the conditions of their doing business in this State is that they are required to be members of MMIA. Presumably if they cease doing that type of business they need no longer be members of MMIA.

Those insurance companies which are members of MMIA are required to make up any deficit which may be incurred by MMIA as a result of its insurance operations.

The rate for the policy year 1984-1985 had been established by the Superintendent based on the findings and recommenda-

tions of Honorable Dominick L. Gabrielli, who had served as a Special Hearing Officer for that purpose. Thereafter, the Superintendent promulgated an amendment to regulation 101 (11 NYCRR part 70), which reduced the 1984-1985 rates by 15%.

A hearing on the rates to be established for 1985-1986 was held before Honorable Matthew J. Jasen who sat as a Special Deputy Superintendent. During the pendency of the hearing the Superintendent, on the basis of the evidence and of the experience up to that time, allowed an interim rate increase of 20% over the base rate. The determination of Judge Jasen was that the rates for the year in question before him should be increased for primary insurance by 86.7%, and for excess insurance by 30% and 20%, respectively, for the two layers of insurance, over the 1984-1985 base rate.

However, before the Superintendent acted upon Judge Jasen's recommendation, the Legislature, reacting to well-known problems in the malpractice insurance field, enacted Laws of 1986 (ch 266). In general, this was a legislative attempt to begin to resolve the problems that were apparent. Specifically, section 40 of that chapter provided a mechanism which allowed the Superintendent to set the rates for the three policy years of 1985-1988; and in the event the experience of those three years resulted in an actuarially projected deficit, provided for a premium surcharge not to exceed 8% on all policies which commenced in the policy year 1989 and to continue for an indeterminate number of years, to satisfy any projected deficiencies which would then be considered attributable to the rates which had been set for the policy years 1985-1988.

Section 40 also provides that the surcharges shall be deemed to be income earned for the purposes of section 2303 of the Insurance Law.

Acting ostensibly under the authority of this enactment, and using 1984-1985 as a base, the Superintendent determined that the premium increases for the periods in question should be as follows:

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	Primary Rate	Excess Rate	
		1st Layer	2nd Layer
1985-86	14%	30%	20%
1986-87	9%	35%	24%
1987-88	9%	40%	28%

The matter was referred, by agreement, to Honorable Samuel S. Silverman, to hear the evidence supporting the contentions of the parties and to report to the court.

It is clear from the evidence before the Referee, and he has reported, that the rates fixed by the Superintendent for both the primary and the two excess layers of insurance are entirely inadequate to meet the statutory standards which have been fixed by the Insurance Law. However, the Referee concluded that the determination of the Superintendent was proper, based upon the effect which he thought should be given to section 40.

I

(a)

There are two sets of statutory standards which are applicable.

The first is found in Insurance Law, article 23, § 2303, which provides that, "Rates shall not be excessive, inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of insurers."

The second standard is found in article 55, which, in section 5505 provides that, "(a) The rates * * * shall be subject to article twenty-three of this chapter, giving due consideration to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this state, trends in the frequency and severity of losses, the investment income of the association, and such other information as the superintendent may require."

To the extent that the rates are subject to article 23, one must look at section 2301, which sets forth the purposes of article 23.

In that connection, it should be noted that while section 2303 sets forth a statement as to what the rates shall *not be*, subdivision (b) of section 5505 provides affirmatively that the rates shall be "on an actuarially sound basis, be calculated to be self-supporting, be based on reasonable standards".

There are different purposes for these two sets of standards which otherwise would seem partially to overlap.

Article 23 applies to all types of insurance written by any insurer authorized to do business within the State; by section 2301 it can be seen that the purpose of article 23 is essentially to promote price competition and competitive behavior among insurers. The prohibition of "inadequate" rates under article 23 is, in general terms, designed to prevent unfair and discriminatory practices and also to maintain the availability and reliability of insurers.

(b)

This court does not agree with the contention of the Superintendent that the direction in section 40 (L 1986, ch 266) to the effect that the surcharge shall be deemed to be income for the purposes of section 2303 was intended to override the direction in section 5505 that the rates which were to be fixed by the Superintendent were to be actuarially sound, self-supporting, and based on reasonable standards.

While courts should give deference to an agency's practical construction of a statute over a period of time (*see, e.g., Town of Amherst v County of Erie*, 260 NY 361, 369-370), the construction proposed here is one of first impression, and is not entitled to absolute judicial deference, since the ultimate responsibility of interpreting the law rests with the court. (*See, Matter of Exxon Corp. v Board of Stds. & Appeals*, 128 AD2d 289, 296.)

While section 40 (L 1986, ch 266) was enacted to restrain and stabilize soaring medical malpractice insurance rates, this court does not conclude that the Legislature, to effectuate that result, intended to change the general rules set forth in the Insurance

Law. The legislative intent to reduce soaring malpractice rates (*see*, L 1986, ch 266, § 1) was to be effectuated by many other means, only one of which was to allow the Superintendent of Insurance to fix rates.

It would be impermissible for the Legislature to effectuate that purpose by requiring that the Superintendent act in such a way as to effectuate an unconstitutional result, which would be the case if the statute were to be read to require rates that did not allow a reasonable rate of return to the petitioner or to its members.

Article 55 refers solely to petitioner, which was created by that article. Under section 5505, the rates are required to be actuarially sound, self-supporting, and are to be based on reasonable standards.

The history of the adoption of the predecessor to article 23 is set forth in *Matter of Smith v Wikler* (10 AD2d 195). Its purpose was to satisfy the requirements of the McCarran-Ferguson Act (15 USC §§ 1011-1012) which imposed a moratorium on the application of Federal antitrust laws to the business of insurance, so long as the business of insurance was regulated by State law.

That purpose, now set forth in section 2301, was to provide for the promotion of price competition and competitive behavior; to provide rates that are responsive to market conditions; to improve the availability and reliability of insurance and to regulate competition among insurers. Rates for those purposes were not to be excessive or inadequate or unfairly discriminatory.

Section 2303, which sets the standards for rates under article 23, implements each of those purposes and to insure the availability and reliability of insurance, states that the rates shall not be detrimental to the solvency of insurers. For these purposes, the Superintendent may broadly include all income on all the insurer's investments of any kind and wherever located.

Thus, an insurer may not be permitted to set an unusually low rate, which might be destructive of competition, or which might lead to insolvency, unless it can be shown that the insurer

has sufficient investment income from all sources to be able to promulgate such a low rate.

The Superintendent has taken the position that despite the present insufficiency of the rates, he has legislative authorization to set them at that level by reason of the last sentence of section 40 (L 1986, ch 266), which, he claims, gives him the right to consider the surcharges to be imposed commencing in 1989 as a part of the rate. He claims that these surcharges, if imposed in 1989 and continued to be imposed on each future annual premium until approximately the year 2000, will be sufficient to make up the deficit for the years 1985-1988 which is presently foreseen as a result of his present rate determination.[1]

He bases this on his conclusion that the Legislature, in enacting Laws of 1986 (ch 266), intended that the rates for 1985-1988 period be inadequate, and that the burden of this intended inadequacy be passed on to a succeeding generation.

However, not only is there no clear language which would permit this interpretation, but an examination of section 40 leads to a contrary conclusion.

Specifically, after directing the Superintendent to establish rates for the 1985-1988 period, the Superintendent is directed to cause the insurers to establish segregated accounts for those years for premium payments, reserves and investment income attributable to that period, and to require periodic reports, "to monitor whether the accounts will be sufficient to meet incurred claims and expenses." (L 1986, ch 266, § 40.)

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1. The Referee found, and both sides appear to agree, that there was no rational basis for the Superintendent's decision in setting excess rates. The Referee concluded that the 8% future surcharge should be considered in setting those rates, but found that even with that surcharge, there was not even a prima facie showing that the excess rates were proper.

There was no showing as to how much of the 8% surcharge will be applied, *in futuro*, to the primary rates and how much to the excess rates, from which this court can only conclude that there was no basis for the optimistic conclusion by the Superintendent that the 8% surcharge will ultimately make up the 1985-1988 deficit.

This language expresses the legislative hope that the rates to be set would be sufficient, under the existing circumstances of general uncertainty in the malpractice insurance field. The language does not support the Superintendent's position that the Legislature intended that the rates be set so that the accounts would be insufficient for that three-year period.

The court reads section 40 to provide that if the rates proved to be inadequate, only then would the surcharge, if necessary, be imposed; and then only up to 8% of the then allowed premiums.

It is clear that the Superintendent was not to impose the full 8% surcharge, unless and until his monitoring of the accounts toward the end of the 1985-1988 period established a necessity for that action.

From all the evidence, it is apparent that the position of the actuaries for the Superintendent, upon whom he relied, was that the surcharge, beginning in 1989, was to be fixed at 8%; and their calculations of the 1985-1988 rates was based on their present determination that the 8% surcharge would be necessary.

Only if section 40 (L 1986, ch 266) were read to require that the Superintendent make the 8% surcharge determination at the present time, instead of waiting (as § 40 seems to require) for the periodic reports during the 1985-1988 period, might the position of the Superintendent be sustained.

(c)

He has not contended, nor was there any evidence adduced before the Referee, that even with the surcharge, there will be an adequate return to enable the members of petitioner to make any return on their compelled investment, at a reasonable profit, which they are entitled to do. (*See*, Insurance Law § 2304[a].) Indeed, if the Legislature had intended to prohibit a reasonable return on investment, there would be serious question as to the constitutionality of the Legislation. (*See*,

Prendergast v New York Tel. Co., 262 US 43;[2] *Brooks-Scanlon Co. v Railroad Commn.*, 251 US 396, 399.)[3]

That MMIA was created as a nonprofit corporation and that membership in MMIA by the member insurers is a condition of their doing business in this State does not give the State, acting through the Superintendent's rate-making powers, the power to require them to invest in or to maintain a losing business for the benefit of others.

(d)

None of the foregoing considers the question of insolvency as a result of the income and expenses up to the 1985-1986 policy year. While the petitioner was not insolvent in the equity sense (that is, it is able to pay its present debts as they mature) the statutory test set forth in section 1309(a) of the Insurance Law is somewhat different. Respondent has conceded, during argument, that the definition in section 1309 is applicable.

While the statute does use the words "unable to pay its outstanding lawful obligations as they mature in the regular course of business", the statutory tests for this are set forth in the next following phrase: "as shown by an excess of required reserves and other liabilities over admitted assets, or by its not having sufficient assets to reinsure all outstanding risks * * * after paying all accrued claims owed". (Insurance Law § 1309[a].)

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2. "They [the temporary rates] were final legislative acts as to the period during which they should remain in effect pending the final determination; and if the rates prescribed were confiscatory the Company would be deprived of a reasonable return upon its property during such period, without remedy, unless their enforcement should be enjoined. Upon a showing that such rates were confiscatory the Company was entitled to have their enforcement enjoined pending the continuance and completion of the rate-making process." (*Prendergast v New York Tel. Co.*, 262 US 43, 49.)

3. "A carrier cannot be compelled to carry on even a branch of business at a loss, much less the whole business of carriage * * * The plaintiff may be making money from its sawmill and lumber business but it no more can be compelled to spend that than it can be compelled to spend any other money to maintain a railroad for the benefit of others who do not care to pay for it." (*Brooks-Scanlon Co. v Railroad Commn.*, 251 US 396, 399.)

The evidence is undisputed that by this test MMIA is insolvent.

In *Stewart v Citizens Cas. Co.* (61 Misc 2d 809, *revd* 34 AD2d 525, *affd* 27 NY2d 685, *cert denied* 401 US 910) insolvency was defined as an excess of reserves over admitted assets. It is clear that the test looks to the future maturation of present and potential claims, against the presently admitted assets.

The Referee found that the proposed rates would not *impermissibly* impair the solvency of MMIA; it seems clear from the evidence that petitioner's solvency is, and will continue to be impaired. If it was the legislative intent to so modify not only section 5505 of the Insurance Law, but long-standing general principles of the requirement of solvency of insurance companies, it is not apparent from the statute.

II

It is difficult for the court, as it was for the Referee, to determine what the basis for the determination of the Superintendent was. The Superintendent's actuaries, who presented him with their conclusions based upon various "scenarios" of rate structures were likewise unable to determine the basis for his action. The scenarios themselves were, as described by one of this actuaries, "not an analysis so much as it is one scenario", and depends upon future results which themselves rest on a speculative foundation with no basis in past experience. This is not an actuarial basis.

There was, therefore, no proper actuarial basis, or other basis before the Superintendent which could serve as a foundation for his determination.

CONCLUSION

Based on the foregoing analysis, the court concludes that the report of the Referee should not be accepted, and that the determination of the Superintendent should be set aside.

APPENDIX E

The Constitution of the United States

Amendment V

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

Amendment XIV

§ 1 All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

APPENDIX F

1986 Laws of New York, Chapter 266

§ 40. The superintendent of insurance shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred eighty-eight. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July first, nineteen hundred eighty-nine, the superintendent shall impose a surcharge on premiums to satisfy any actuarially projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the approved adequate rate and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. On and after July first, nineteen hundred eighty-nine, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July first, nineteen hundred eighty-five through June thirtieth, nineteen hundred eighty-eight policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods. In the event any insurer that provided coverage during such policy periods is in liquidation, the

property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law.

APPENDIX G

Insurance Department of the State of New York
Tenth Amendment to Regulation No. 101
(11 NYCRR 70)

MEDICAL MALPRACTICE INSURANCE RATE MODIFICATIONS, PROVISIONAL RATES, REQUIRED POLICY PROVISIONS, AND AVAILABILITY OF COVERAGE

I, JAMES P. CORCORAN, Superintendent of Insurance of the State of New York, pursuant to the authority granted by Sections 201, 301, 1103, 1113(a)(13) and (14), 3437, 5502, 5504, 6302, 6303, and Article 23 of the Insurance Law, and Chapter 266 of the Laws of 1986, do hereby promulgate, on an emergency basis, the following amendment to Part 70 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Tenth Amendment to Insurance Department Regulation Number 101), to take effect immediately upon filing with the Secretary of State, to read as follows: Section 70.1 is hereby amended by adding a new subdivision (l) as follows:

(l) Purchasing group means any group formed pursuant to the federal "Liability Risk Retention Act of 1986" ("LRRA") (15 U.S.C. 3901 et. seg.) and:

(1) has as one of its purposes the purchase of liability insurance on a group basis;

(2) purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in paragraph (3) this subdivision;

(3) is composed of members whose business or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(4) is domiciled in any state.

Section 70.8 is hereby amended as follows:

Section 70.8. Physicians Medical Malpractice Liability Insurance Rates for Claims-made and Occurrence Primary and Excess Policies and Claims-made Tail Coverage

(a) Pending enactment of Chapter 266 of the Laws of 1986, which was signed into law on July 8, 1986, all physicians medical malpractice liability insurers were directed by the Fifth Amendment to Part 70 (Section 70.8 repealed by [this] *the Eighth* amendment *of this part*) that the rates for the policy period commencing July 1, 1986, and ending June 30, 1987 would continue to be, on a provisional basis, the rates last approved by the Department for said insurers. All insurers that issued policies of medical malpractice liability insurance, as defined in Section 70.1(a) of this Part, and all insurers with special licenses under Section 6302 of the Insurance Law that issued policies including such coverage, were directed to furnish their insureds with the following endorsement in connection with all such policies in effect on and after July 1, 1986:

> "THE PREMIUMS ON THIS POLICY FOR THE PERIOD OF COVERAGE COMMENCING ON OR AFTER JULY 1, 1986 THROUGH JUNE 30, 1987 ARE PROVISIONAL AND ARE SUBJECT TO UPWARD OR DOWNWARD ADJUSTMENT. INSUREDS MAY BE REQUIRED TO PAY AN AMENDED PREMIUM RETROACTIVE TO JULY 1, 1986, OR THE ANNIVERSARY DATE OF THE POLICY, WHICHEVER IS LATER OR BE ENTITLED TO A CREDIT IF IT IS DETERMINED THAT A DOWNWARD ADJUSTMENT IS NECESSARY IN ORDER TO MEET STATUTORY RATING STANDARDS."

(b) Pursuant to Section 40 of Chapter 266 of the Laws of 1986, the Superintendent was directed to establish rates for pol-

icies providing coverage for physicians medical malpractice liability insurance for the periods commencing July 1, 1985 and ending June 30, 1988. The rates established herein for policies issued or renewed during the year July 1, 1985 through June 30, 1986 supersede the provisional rates mandated by Section 70.5 for primary coverage and by Section 70.6 for excess coverage, and interim rate increases, if any, approved by the Superintendent for such policy year, and the rates established by prior amendment of this Section, where inconsistent with this amendment. The rates established herein for policies issued or renewed during the year July 1, 1986 through June 30, 1987 supersede the rates established by prior amendment of this Section, where inconsistent with this amendment. Insurers shall charge a rate for physicians medical malpractice liability insurance only as established by the Superintendent.

(c) *Base year occurrence rates:*

(1) For the purposes of this Part, the base year occurrence rate shall be the occurrence rate approved for the insurer by the Superintendent for policies issued or renewed during the year July 1, 1984 through June 30, 1985, as reduced by the fifteen percent downward modification mandated by Section 70.5(c)(1).

(2) For any insurer that had no base year occurrence rate as provided in paragraph (1) of this subdivision, but had a claims-made rate approved, the base year occurrence rate shall be the third year claims-made rate approved by the Superintendent, as reduced by the fifteen percent downward modification mandated by Section 70.5(c)(1), multiplied by 1.158.

(3) For any insurer that utilized a rate which has not been approved by the Superintendent, and for any insurer that has not previously written policies subject to this Part, the base year occurrence rate shall be the approved rate of another insurer, that is most appropriate for that insurer, together with any modification which can be adequately supported. Such rate shall not be used until established by the Superintendent.

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(d) *Rating plans*

(1) For any insurer that utililized a rating plan which has not been approved by the Superintendent, and for any insurer that has not previously written policies subject to this Part, the rating plan shall be the approved rating plan of another insurer that is most appropriate for that insurer, together with any modification which can be adequately supported. Such plan may not be used until it is approved by the Superintendent.

(2) For any insurer that currently has an approved rating plan, such insurer shall continue to use such rating plan, except that the insurer may adopt the approved rating plan of another insurer that is most appropriate for that insurer. In either case no modification shall be permitted unless it can be adequately supported and results in no overall rate level change for the insurer. No modification or alternate rating plan may be adopted for policies issued prior to July 1, 1986. Any modified or alternate rating plan may not be used until it is approved by the Superintendent.

(e) *Occurrence primary and excess coverage rates*

(1) Rates for occurrence policies issued or renewed during the year July 1, 1985 through June 30, 1986:

(i) For primary coverage, up to $1 million/$3 million, the rate shall be 14% greater than the base year occurrence rate;

(ii) For a first excess layer providing $1 million/$3million of excess coverage above $1 million/$3 million primary coverage, the rate shall be 30 percent of the $1 million/$3 million rate for primary coverage established in subparagraph (i) of this paragraph:

(iii) For a second excess layer providing $1 million/$3 million of excess coverage above the underlying primary coverage and first layer of excess coverage, described in subparagraph (ii) of this paragraph, the rate shall be 20 percent of the $1 million/

$3 million rate for primary coverage established in subparagraph (i) of this paragraph:

(2) Rates for occurrence policies issued or renewed during the year July 1, 1986 through June 30, 1987:

(i) For primary coverage, up to $1 million/$3 million, the rate shall be 9 percent greater than that established pursuant to paragraph (1)(i) of this subdivision;

(ii) For a first excess layer providing $1 million/$3million of excess coverage above $1 million/$3 million primary coverage, the rate shall be 35 percent of the $1 million/$3 million rate for primary coverage established in subparagraph (i) of this paragraph;

(iii) For a second excess layer providing $1 million/$3 million of excess coverage above the underlying primary coverage and first layer of excess coverage, described in subparagraph (ii) of this paragraph, the rate shall be 24 percent of the $1 million/$3 million rate for primary coverage established in subparagraph (i) of this paragraph.

(3) Rates for occurrence policies issued or renewed during the year July 1, 1987 through June 30, 1988:

(i) For primary coverage, up to $1 million/$3 million, the rate shall be 9 percent greater than that established pursuant to paragraph (2)(i) of this subdivision;

(ii) For a first excess layer providing $1 million/$3 million of excess coverage above $1 million/$3 million primary coverage, the rate shall be 40 percent of the $1 million/$3 million rate for primary coverage established in subparagraph (i) of this paragraph;

(iii) For a second excess layer providing $1 million/$3 million of excess coverage above the underlying primary coverage and first layer of excess coverage, described in subparagraph (ii) of this paragraph, the rate shall be 28 percent of the $1 million/

$3 million rate for primary coverage established in subparagraph (i) of this paragraph.

(4) The rates for the excess layers apply to policies purchased directly by physicians and to policies purchased by general hospitals on behalf of their eligible physicians, as required by Section 19 of Chapter 294 of the Laws of 1985 and by Section 18 of Chapter 266 of the Laws of 1986.

[(4)]*(5)*. The rates for occurrence excess layer policies providing coverage other than as specifically established herein shall be established by the Superintendent after a review of proposed rates and supporting documentation to be submitted by each insurer writing such coverage, in accordance with subdivision (j)(3) herein. The Superintendent shall consider such submissions, as well as any other relevant factors, and will thereafter establish a rate for each such excess layer.

(f) Claims-made primary and excess coverage rates

(1) Claims-made primary coverage rates

The claims-made rate for a particular primary coverage policy shall be the corresponding occurrence rate multiplied by the appropriate claims-made factor, as follows:

Year in Claims-Made Program	*Claims-made Factor*
First:	31%
Second:	64
Third:	85
Fourth:	94
Fifth:	99
Sixth:	*102*

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(2) Optional Extended Reporting Period (Tail) Primary Coverage Rates

(i) The rate for optional tail coverage that is required to be offered for a particular claims-made primary coverage policy shall be the corresponding occurrence rate multiplied by the appropriate tail factor, as follows:

Number of years completed in Claims-Made Program	*Tail Factor*
One:	74.8%
Two:	122.1
Three:	146.4
Four:	162.4
Five:	173.3
Sixth:	*181.0*

(ii) For a policy terminated on a date other than the policy anniversary date, the tail factor shall be obtained by interpolating, on a daily basis, between the tail factors applicable to the last and next policy anniversaries.

(iii) For any policy that was written at a reduced rate because the insured was eligible for a new doctor discount, the tail premium shall be reduced by a percentage equal to the percentage that the current year's rate (exclusive of any surplus contributions) was reduced as a result of such new doctor discount.

(3) Rates for claims-made and tail excess coverage policies purchased by hospitals

The aggregate rate for a claims-made excess coverage policy and its simultaneously issued tail (as mandated by subdivision (g) herein) purchased by a general hospital on behalf of a physician, shall be equal to the corresponding occurrence excess coverage rate.

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(4) Rates for claims-made and tail excess coverage policies purchased by physicians directly

The rates for the claims-made and tail first and second excess layers required to be offered when purchased directly by a physician, and the rates for any other claims-made and tail excess layer other than as specified herein, shall be established by the Superintendent after a review of proposed rates and supporting documents to be submitted by each insurer writing, or required to write, such coverage, in accordance with subdivision (j)(3) herein. The Superintendent shall consider such submissions, as well as any other relevant factors, and will thereafter establish a rate for each such excess layer.

(g) Excess Coverage—Types of Policies; Required Tail

(1) Pursuant to Section 19 of Chapter 294 of the Laws of 1985, and as established in Section 70.(7)(c), excess coverage policies providing $1 million/$3 million of excess coverage above $1 million/$3 million primary coverage, purchased by general hospitals on behalf of physicians, afforded such coverage for "occurrences" between July 1, 1985 through June 30, 1986 and were issued on an "occurrence" basis.

(2) Pursuant to Section 18 of Chapter 266 of the Laws of 1986, excess coverage policies providing $1 million/$3 million of excess coverage above $1 million/$3 million primary coverage, purchased by general hospitals on behalf of physicians, shall provide such coverage for "occurrences" between July 1, 1986 and June 30, 1987. Accordingly, all physicians medical malpractice liability insurers which issue such an excess policy on a claims-made basis shall simultaneously issue full tail coverage.

(3) Except where required to be issued on a claims-made basis pursuant to Section 5504(f), excess coverage policies issued or renewed or and after July 1, 1986 shall provide coverage on either an occurrence or claims-made basis, subject to paragraph (2) of this subdivision, provided that:

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(i) An excess coverage policy shall be renewed on the same basis (occurrence or claims-made) as it was previously issued, except that the insured may choose to substitute claims-made coverage for occurrence coverage.

(ii) If the insured so requests, an excess coverage policy issued by the same insurer that issued the underlying primary coverage shall be issued with the same type of coverage (occurrence or claims-made) as the primary coverage.

(4) The provisions of Sections 70.7(b)(2) and (d) continue to be applicable to all medical malpractice liability insurers.

(h) Segregated accounts

Physicians medical malpractice insurers shall establish segregated accounts for premiums, reserves, and investment income attributable to such policy year periods contained in subdivision (b) hereof, and are further required to report to the Insurance Department on a quarterly basis regarding claims and expenses attributable to such periods.

(i) Required filings-primary coverage

(1) All physicians medical malpractice liability insurers were required to file by August 1, 1986 amended rate manual pages with the Superintendent in accordance with the primary coverage rates established by prior amendments of this Part. Any such insurer not previously issuing a policy on a claims-made form was required to file such form for approval at the same time.

(2) [In accordance with this amendment, all] *All* such insurers are required to file by December 31, 1986 amended rate manual pages with the Superintendent in accordance with the primary coverage rates established [herein] *by the eighth amendment to this Part.*

(3) All such insurers are required to file by July 15, 1987 amended rate manual pages with the Superintendent in accord-

ance with the primary coverage rates established by the tenth amendment to this Part.

(j) Required filings-excess coverage

(1) All physicians medical malpractice liability insurers were required to file by August 22, 1986 amended rate manual pages with the Superintendent in accordance with the excess coverage rates established by prior amendments of this Part.

(2)(i) All such insurers are required to file by December 31, 1986 amended rate manual pages with the Superintendent in accordance with the excess coverage rates specifically established *[*herein*]* *by the eighth amendment to this Part.*

(ii) All such insurers are required to file by July 15, 1987 amended rate manual pages with the Superintendent in accordance with the excess coverage rates specifically established by the tenth amendment to this Part.

(3) Insurers writing, or required to write excess layers other than for which rates are specifically established herein shall file, by December 31, 1986, proposed rates with supporting documentation. *For the policy year 1987-1988, such insurers shall file by July 15, 1987 proposed rates with supporting documentation.*

(k) Rate Service organization

(1) A physicians medical malpractice liability insurance rate filed by a rate service organization on behalf of its members and subscribers shall be established in accordance with this Section. Any such organization shall make the appropriate rate filing required by subdivisions (i) and (j) of this section by December 31, 1986. *For the policy year 1987-1988, such organization shall make the appropriate rate filing by July 15, 1987.*

(2) A member or subscriber of a rate service organization may adopt the established rates and approved rating plan filed by the organization if said member or subscriber notifies the

Appendix G

Department by December 31, 1986 and the Department determines that such filing is not inappropriate. *For the policy year 1987-1988, the member or subscriber shall notify the Department by July 15, 1987 that it is adopting such rates.*

(l) Purchasing groups

The rates and rating plan for medical malpractice liability insurance issued to a purchasing group and its members shall be established in accordance with the provisions of this part, except that, where the insurer and the purchasing group has complied with all applicable provisions of the LRRA, if an insurer submits rates or a rating plan affording advantages, based on the purchasing group's loss and expense experience, not afforded to other persons, the Superintendent shall review such submission, and thereafter establish rates or a rating plan, as appropriate, reflecting such advantages. Any such insurer shall file by July 15, 1987 proposed rates adequately supported.

m) Required filing-rating plans

(1) All physicians medical malpractice liability insurers shall file with the Superintendent by August 15, 1987 adequate support for their rating plans (as defined in this Part, but excluding the merit rating plan). Such insurers shall include actuarial data and other relevant considerations.

(2) Any insurer who has adopted the rating plan of another insurer, pursuant to subdivision (d) of this section may instead submit to the Superintendent a statement to that effect. Such statement will be deemed to be compliance with paragraph (1) of this subdivision.

No. 88-1520

Supreme Court, U.S.
FILED
MAY 1 1989
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

MEDICAL MALPRACTICE INSURANCE ASSOCIATION,
Petitioner,

—against—

SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

No. 88-1520

MEDICAL MALPRACTICE INSURANCE ASSOCIATION,
Petitioner,

—against—

SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,
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PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Introduction

This action challenges a determination of the respondent Superintendent pursuant to a temporary rate stabilization program enacted as one aspect of a comprehensive scheme adopted in the Medical Malpractice Reform Act of 1986, 1986 N.Y. Laws, ch. 266. Petitioner Medical Malpractice Insurance Association ("MMIA") seeks review of an order of the Court of Appeals of the State of New York dated December 15, 1988

(App. A at 15a),[1] which unanimously upheld the Superintendent's determination.

The challenged determination is set forth in amendments to the Superintendent's Regulation 101, 11 New York Codes, Rules and Regulations ("N.Y.C.R.R.") § 70.8 *et seq.* (App. G). The mandate to the Superintendent to implement a temporary rate stabilization program (1986 N.Y. Laws, ch. 266, §§ 1, 40) complemented numerous and significant reforms designed to prevent instances of medical malpractice and assure that both malpractice verdicts and litigation costs are reasonable. 1985 N.Y. Laws, ch. 294; 1986 N.Y. Laws, chs. 266, 682.

The Court of Appeals held that the Superintendent's interpretation of section 40 of the 1986 Act was reasonable and that the rates set pursuant to that interpretation were not arbitrary or capricious. The Court further held that MMIA's allegation that the Superintendent's interpretation would result in a confiscation of property in violation of the Fifth and Fourteenth Amendments of the United States Constitution, as well as parallel provisions of the New York State Constitution, would not lie, given that MMIA is "a creature of statute" that is separate and distinct from its members. (App. A).

In its petition to this Court, MMIA challenges the Court of Appeals' holding that the Superintendent's interpretation of section 40 of the 1986 Act does not violate the Fifth and Fourteenth Amendments of the United States Constitution. As will be shown, the petition should be denied because MMIA is not an entity which can properly advance a claim under the Takings Clause of the United States Constitution, its claim is not yet ripe for adjudication, and the temporary rate stabilization program adopted pursuant to section 40 is both reasonable and non-confiscatory. Indeed, contrary to the suggestions in the briefs of petitioner and *amicus curiae*, section 40 is designed to guarantee adequate rates through a system of surcharges, the

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1 "App." denotes the Appendix to the Petition for a Writ of Certiorari to the Court of Appeals of the State of New York. "A." denotes the Appendix in the Appellate Division, First Department, of the Supreme Court of the State of New York.

imposition of which will become mandatory should actuarial deficits be projected for the policy years in question.

Statement Of The Case

The Superintendent adopts section I of the opinion of the Court of Appeals (App. A at 2a-6a) as his statement of the case with respect to all matters prior to the Court of Appeals' decision. As that court noted, the Appellate Division of the Supreme Court of the State of New York affirmed, by a 3 to 2 vote, the decision of the trial court rejecting a referee's report and setting aside the Superintendent's rate determinations.

The Court of Appeals unanimously reversed the decision of the Appellate Division. It held that the Superintendent's consideration of future surcharges in setting rates for the 1985-1988 policy years reflected a reasonable interpretation of the relevant statutory provisions and that the rates he had set pursuant to that interpretation were not arbitrary or capricious and were rationally based on actuarial data. (App. A at 2a, 9a-11a).

The court rejected MMIA's argument that the Superintendent's interpretation was arbitrary because it would require MMIA to run at a deficit for an unreasonable length of time. It noted that any actuarially projected deficiency ultimately attributed to restrained rates for the 1985-88 period would be recouped by the surcharges within 15 years, and that MMIA would remain liquid throughout this period, *i.e.*, able to pay claims as they came due, by virtue of the established rates in combination with 8% surcharges after 1989. (App. A at 12a). The court further observed that given the tort reforms enacted in 1985 and 1986, and the uniquely long-tailed nature of medical malpractice claims, this result was "entirely reasonable." (App. A at 12a).

The court also held that requiring MMIA to operate under an actuarially projected deficit was not confiscatory, because:

> MMIA is a creature of statute, and all of its rights, obligations and duties have been defined by the Legislature (*see*,

> Insurance Law art 55). MMIA may operate only for fixed periods of time and only if the Superintendent determines that medical malpractice insurance is not readily available in the voluntary market (Insurance Law § 5502[d]). In addition, MMIA's operations are subject to the Superintendent's extensive and direct control (Insurance Law § 5503[c]). Importantly, although all insurance companies writing personal injury insurance in New York are required to be members of MMIA as a condition of transacting business in this State (Insurance Law § 5502[a]), MMIA is a nonprofit unincorporated association which is a legal entity separate and distinct from its members (Insurance Law § 5502[b]). Moreover, all funds and reserves of MMIA are held and invested separately from its members (*id.*).

72 N.Y.2d 753, 766.[2]

The court observed that "deficits were expressly contemplated in the enabling legislation (Insurance Law §§ 5507, 5509)." 72 N.Y.2d at 766. (App. A at 13a). The court thus concluded that

> even if MMIA will operate at a continued loss, such a loss is not confiscatory vis-à-vis MMIA (*see, Brooks-Scanlon Co. v. Railroad Commn.*, 251 US 396, 399 ["It is true that if a railroad continues to exercise the power conferred upon it by a charter from a State, the State may require it to fulfil an obligation imposed by the charter, even though fulfilment in that particular may cause a loss."]; *Missouri Pac. Ry. Co. v. Kansas*, 216 US 262, 276, 278); *Atlantic Coast Line v. North Carolina Corp. Commn.*, 206 US 1).

Id.

Regarding MMIA's suggestion, raised for the first time in its brief to that court, that the rates set by the Superintendent

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2 There is a typographical error in this quotation as it appears in the appendix to the petition. (App. A at 13a). The first reference to section 5502[d] is transcribed there as 5505[d].

would violate the rights of MMIA's members, as opposed to MMIA itself, the court observed that these members had never been made parties to the instant proceeding and that their claims were the subject of a separate action in federal court. That action, *Alliance of American Insurers v. Cuomo*, 87 Civ. 0169 (Patterson, U.S.D.J.), has been held to be justiciable, 854 F.2d 591 (2d Cir. 1988), and is now pending in the United States District Court for the Southern District of New York. Extensive discovery is underway. The Court of Appeals, accordingly, declined to consider that argument. (App. A at 13a-14a).

REASONS FOR DENYING THE WRIT

POINT I

MMIA HAS FAILED TO DEMONSTRATE THAT AN ENTITY OF ITS NATURE CAN ASSERT A TAKING CLAIM

By this petition, MMIA seeks to challenge a decision of the Court of Appeals of the State of New York which held, *inter alia*, that the very nature of MMIA precludes its assertion of a taking claim. The court noted that Article 55 of the Insurance Law—MMIA's legislative charter—makes no mention of any return on investment and explicitly provides that MMIA is a non-profit association. Indeed, MMIA is composed of liability insurers, as a compulsory condition of their doing business in New York, rather than investors expecting to fulfill a legislative promise of a reasonable return (compare New York Public Service Law § 72). The possibility of actuarial deficits was clearly contemplated as part of the legislative scheme. *See* Insurance Law § 5502(a), (b) ("The association shall be a non-profit unincorporated association constituting a legal entity separate and distinct from its members"); §§ 5507, 5509 (stabilization reserve fund created to pay MMIA any deficit or reimburse MMIA members for payment of their allocated shares of MMIA deficits). In contrast to a proprietary business or a public utility, MMIA may legally operate only for fixed periods and only if the Superintendent determines that medical malpractice

insurance is not readily available in the voluntary market. Insurance Law § 5502(d). And MMIA's operations are subject to the Superintendent's extensive and direct control. Insurance Law § 5503(c). Thus, the Court of Appeals saw little resemblance in MMIA to an investment-backed enterprise aggrieved by confiscatory rates.

The threshold issue presented by this petition is whether there is a conflict between the Court of Appeals' decision and any decision of this Court or another appellate court or, alternatively, whether the decision presents an important federal question that should be resolved by this Court. None of the Supreme Court or other cases MMIA cites even addresses the question of whether regulation can effect a taking as to an association like MMIA, or whether such an association may present the claims of non-party members.[3] Moreover, given that individual members have the right to challenge the regulatory scheme, and that such litigation is, in fact, pending, MMIA has not demonstrated that it is important for this Court to resolve that question. Thus, MMIA has failed to make the requisite showing.

The insuperable obstacle to MMIA's taking claim is that it cannot properly be evaluated without measuring the impact of the rates on the individual insurers which comprise MMIA, as opposed to the association itself. This Court's recent decision in *Duquesne Light Co. v. Barasch*, 109 S.Ct. 609, 619 (1989), teaches that only rate-making with a confiscatory impact is unconstitutional. In assessing the economic impact of a regulation, moreover, the value of the complainant's property interest in the enterprise, and its investment-backed expectations of a profit, are central considerations. *Williamson County Regional*

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3 *California State Automobile Association v. Maloney*, 341 U.S. 105 (1951), involved an assigned risk plan allocating less desirable applicants among all insurers doing auto insurance business in the state. The plaintiff there was merely one of the insurers. Although it was, in fact, "an unincorporated association" analogous to a mutual insurance company, *id.* at 106, it had been formed voluntarily, by its members, "to write automobile insurance to a select group of members at a lower cost than the prevailing rate," *id.*, and thus was not a "creature of statute" like MMIA, which has a legal identity separate and distinct from its members (Insurance Law § 5502(b)).

Planning Commission v. Hamilton Bank, 473 U.S. 172, 191 (1985). *Accord Keystone Bituminous Coal Association v. De Benedictis*, 107 S.Ct. 1232, 1246-1248 (1987); *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 225 (1986). Since MMIA, as a creature of statute, does not itself have any "investment-backed expectations," it is only by showing the impact of the rates here on its members that MMIA could conceivably demonstrate that such rates are confiscatory.

MMIA, however, made no attempt in its petition pursuant to Article 78 of the New York Civil Practice Law and Rules ("CPLR")[4] to assert the claims of its members (A. 26-40, 137-54, 172-87, 275-94), and the record is silent as to the impact of the Superintendent's application of section 40 on MMIA members' businesses. Indeed, MMIA did not purport to advocate on its members' behalf until it filed its brief in response to the Superintendent's appeal to the Court of Appeals. Moreover, it failed to demonstrate, even then, why it should be permitted to assert claims on its members' behalf. In fact, under governing standards, it has no such right.

In *Hunt v. Washington State Apple Advertising Commission*, 432 U.S. 333 (1977), this Court set forth the test to be applied in determining whether a trade association has standing to sue on behalf of its members. The entity has standing "when: (a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Id.* at 343. *Accord*, *New York State Club Association v. City of New York*, 108 S.Ct. 2225, 2232 (1988). Advocating on behalf of its members is not germane to the existence of MMIA, as its purpose is defined under Article 55, and in contrast to a trade association. More fundamentally, MMIA cannot meet the third part of the *Hunt* test because it cannot establish that the rates here are confiscatory as to its members without their participation. Even if MMIA theoreti-

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4 Article 78 establishes a mechanism for obtaining relief in the nature of writs of certiorari to review, mandamus, or prohibition from governmental bodies or officers. CPLR § 7801.

cally could have asserted claims on behalf of its members, the record before the Court of Appeals was utterly inadequate to establish any such claim. Indeed, despite repeated references by petitioner and *amicus curiae* to MMIA's alleged existing deficit, the record is devoid of any evidence that MMIA's members have ever been assessed with regard to that deficit.

As noted above, MMIA's members are presently seeking relief in a separate action, now pending in the United States District Court for the Southern District of New York, *Alliance of American Insurers v. Cuomo*, 87 Civ. 0169 (Patterson, U.S.D.J.). Extensive discovery is taking place in that action, and it represents a far more appropriate vehicle for the adjudication of members' claims. As demonstrated in Point III below, the Court of Appeals' evaluation of MMIA's taking claim here is fully consistent with *California State Automobile Association v. Maloney*, 341 U.S. 105 (1951), and recent rate cases decided by this Court, including *Duquesne*. As there is no special or important reason for the Court to exercise jurisdiction over this case, the Court need not take this occasion to revisit *Duquesne*, *Maloney* and other taking authorities.

POINT II

MMIA'S CLAIM THAT THE SUPERINTENDENT'S RATES ARE CONFISCATORY IS NOT YET RIPE FOR REVIEW IN AN ARTICLE III COURT

MMIA's constitutional challenge to section 40 rests on the assumption that the base rates adopted by the Superintendent for the 1985 through 1988 policy years will result in actuarially projected deficiencies for these years despite the tort reforms enacted in 1985 and 1986. MMIA asserts that these rates, therefore, will effect a taking. Even if MMIA could ever assert such a claim, it is premature here under the ripeness doctrine applied by this Court pursuant to Article III of the Constitution and prudential considerations. *See New York State Club Association v. City of New York*, 108 S.Ct. 2225, 2231 n.2 (1988). MMIA's claim is unripe both because it is not yet known

whether actuarial deficiencies will be projected and because MMIA, by operation of section 40, will, in fact, be compensated for any such actuarially projected deficiencies before they become actual dollar shortfalls. Although the Superintendent declined, at the hearing below, to present evidence that the 1985-88 rates would be adequate without the surcharges, he has never conceded that the base rates are inadequate. The projection as to the existence or non-existence of an actuarial deficit for these policy years has not yet occurred; when it does occur, the rates may prove to be adequate.

As noted by the Court of Appeals, one of the purposes of the 1986 Act was to " 'provide a measure of badly needed premium stability' " as the comprehensive tort reforms enacted in 1985 and 1986 began to take effect. In general, the Superintendent was to set rates pursuant to the same standards previously applied to insurers' filings.[5] There was one difference, however. The surcharges would be deemed to be "income earned" for the purposes of Insurance Law § 2303, which requires that all income earned be included in determining whether rates comply with the statutory requirements of solvency. Thus, the surcharges were to be treated similarly to projected investment income. Only the experience of the next few years will establish whether the rates set for 1985-88 will in fact result in actuarially projected deficiencies for these years, even after the impact of the 1985 and 1986 legislation has been felt. Early indications, however, suggest that this impact may be substantial and favorable. *See Malpractice Bills Stalled by Drop in Suits*, N.Y.L.J., April 25, 1989, at 1, col. 3 (noting that the number of medical malpractice suits filed annually in New York courts has declined by 70% since 1986).

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5 In the period from 1975 until 1985, applicable premium rates were set pursuant to proposals filed by MMIA and other insurers. The Superintendent's role was merely to approve these filings, if they were in compliance with applicable rating standards. These standards required that rates be set at the lowest possible level consistent with solvency and the establishment of reasonable reserves and surpluses. Insurance Law §§ 2303, 5505(a), (b). Nevertheless, MMIA's rates were permitted to increase by more than 200% between 1980 and 1985. (A. 1153-1154).

In *Pennell v. City of San Jose*, 108 S.Ct. 849, 857 (1988), this Court held that the mere fact that a particular outcome is conceivable "does not present a sufficiently concrete factual setting for the adjudication of [a] takings claim." The Court further observed that "[g]iven the 'essentially ad hoc, factual inquir[y]' involved in the takings analysis, . . . we have found it particularly important in takings cases to adhere to our admonition that 'the constitutionality of statutes ought not be decided except in an actual factual setting that makes such a decision necessary.' " *Id.* at 856.

Even if deficiencies had already been projected here, the taking claim would not yet be ripe. Contrary to the suggestion in the briefs of the petitioner and *amicus curiae* American Insurance Association ("AIA"), compliance by the Superintendent with the terms of section 40 is not in any sense permissive. Section 40 states that "the superintendent *shall* impose a surcharge on premiums *to satisfy* any actuarially projected deficiency that is attributable to the premium levels established pursuant to this section . . . ." (Emphasis supplied). The Court of Appeals clearly understood section 40 to require the imposition of appropriate surcharges, guaranteed to offset these deficiencies before MMIA experiences any actual dollar loss.[6] (App. A at 12a). No action by MMIA or its members is necessary to make this requirement operative, and the suggestion that the Superin-

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6 AIA's suggestion, at page 9 note 8 of its brief, that the Superintendent may select the timing and the amount of such surcharges at whim is also contrary to the plain meaning of the statute and its interpretation by the Court of Appeals. Moreover, the 1988 amendments to section 40 explicitly require that projected deficiencies be satisfied within a reasonable time period, and increased the maximum surcharge to 25%, beginning in the 1991-92 policy year, and continuing until any deficiencies have been recouped, in order to ensure that result. 1988 N.Y. Laws, ch. 184, § 19; 1988 N.Y. Laws, ch. 186. The text of the 1988 amendments is set forth in an appendix to this brief. Were the Superintendent to delay imposing a required surcharge, or to impose less than the amount required to ensure an adequate rate, that failure would be actionable, as unreasonable, under Article 78. CPLR § 7801 *et seq.* Similarly, were the Superintendent to impose a surcharge on an inadequate base rate, the inadequacy of the base rate would itself be actionable.

tendent will ignore his duty is purely speculative. As this Court observed, in upholding a state licensing statute, in *New York ex rel. Lieberman v. Van De Carr*, 199 U.S. 552, 562 (1905), "[t]here is no presumption that the power will be arbitrarily exercised . . . ."

Moreover, even if the Superintendent were to fail to comply with his statutory obligation, MMIA would have a remedy. An Article 78 proceeding in the nature of mandamus could be commenced to compel him to take appropriate action.[7] Any constitutional claims MMIA might then possess could also be adjudicated in such a proceeding. As of today, however, MMIA's claim is premature. As this Court observed in *Williamson County Regional Planning Commission v. Hamilton County*, 473 U.S. 172, 194-195 (1985):

> The Fifth Amendment does not proscribe the taking of property; it proscribes taking without just compensation. *Hodel v. Virginia Surface Mining & Reclamation Assn., Inc.*, 452 U.S. [264], at 297, n. 40. Nor does the Fifth Amendment require that just compensation be paid in advance of, or contemporaneously with, the taking; all that is required is that a " 'reasonable, certain and adequate provision for obtaining compensation' " exist at the time of the taking. . . . If the government has provided an adequate process for obtaining compensation, and if resort to that process "yield[s] just compensation," then the property owner "has no claim against the Government" for a taking. . . . [I]f a State provides an adequate procedure for seeking just compensation, the property owner cannot claim a violation of the Just Compensation

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7 MMIA never judicially challenged the adequacy of any of the rates set between 1975 and 1985. In fact, in 1985, MMIA joined with the Superintendent in defending a 42% rate increase, approved by the Superintendent, from a challenge by a physician policyholder. *Schwartz v. Corcoran*, 118 A.D.2d 355, 505 N.Y.S.2d 401 (1st Dept. 1986). Moreover, MMIA declined to collect a substantial portion of the rate increase authorized for the 1981-82 policy year. (A. 1156-1158).

> Clause until it has used the procedure and been denied just compensation.

Given that no deficits have as yet been projected, that section 40 guarantees adequate compensation for any actuarially projected deficiencies which may subsequently arise, that the State has provided a mechanism to compel the Superintendent's compliance with that guarantee, and that MMIA has not yet had occasion to even use that procedure, let alone be denied compensation, its claim here is not yet ripe.

POINT III

THE RATES ARE CLEARLY REASONABLE AND NON-CONFISCATORY UNDER THE DECISIONS OF THIS COURT

Even if MMIA could assert a taking claim, and the claim were deemed ripe for review in an Article III court, MMIA's argument that the Superintendent's application of section 40 is confiscatory runs counter to numerous decisions of this Court rejecting similar constitutional attacks on remedial or rate-making legislation, even when mounted by profit-making enterprises.

In *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211 (1986), for example, this Court dismissed a taking claim, holding that even government regulation which required a proprietary company to subsidize others without compensation was constitutional.

> [A]ppellants' submission—that such a statutory liability to a private party always constitutes an uncompensated taking prohibited by the Fifth Amendment—if accepted, would prove too much. In the course of regulating commercial and other human affairs, Congress routinely creates burdens for some that directly benefit others. For example, Congress may set minimum wages, control prices, or create causes of action that did not previously exist. Given the propriety of the governmental power to

> regulate, it cannot be said that the Taking Clause is violated whenever legislation requires one person to use his or her assets for the benefit of another.

475 U.S. at 222-23. *See also Keystone Bituminous Coal Association v. De Benedictis*, 107 S.Ct. 1232, 1244-45 (1987); *Penn Central Transportation Co. v. New York City*, 438 U.S. 104, 124 (1978).

More recently, in *Duquesne Light Co. v. Barasch*, 109 S.Ct. 609, 619 (1989), the Court rejected a challenge under the Takings Clause to rates set pursuant to a statutory amendment requiring previously recognized costs to be excluded from the rate base, observing:

> The economic judgments required in rate proceedings are often hopelessly complex and do not admit of a single correct result. The Constitution is not designed to arbitrate these economic niceties. Errors to the detriment of one party may well be canceled out by countervailing errors or allowances in another part of the rate proceeding. The *Constitution protects the utility from the net effect of the rate order on its property. Inconsistencies in one aspect of the methodology have no constitutional effect on the utility's property if they are compensated by countervailing factors in some other aspect.*

(Emphasis supplied). *See also Permian Basin Area Rate Cases*, 390 U.S. 747, 770 (1968).

MMIA's taking claim is doomed, in part, because it is based on the false premise that the rates adopted by the Superintendent are "inadequate." As noted previously, however, section 40 does not contemplate that MMIA will suffer actual dollar losses from actually paid claims; the statutory surcharges are intended to prevent that adversity. Thus, the referee who conducted the trial, in rejecting MMIA's due process argument, found that the Superintendent's application of section 40 would not cause MMIA to become insolvent. As he stated: "Section 40 does not purport to require the fixing of inadequate rates." (A. 209, 233). Similarly, the Court of Appeals, after consider-

ing the extensive record in this case, held that the Superintendent properly treated the future surcharges as income and concluded that base rates with the surcharges would be adequate and reasonable.

Section 40 comprises but one component of comprehensive reform legislation, enacted in 1985, 1986 and 1988, that in a wide variety of ways would *decrease* insurance companies' exposure, by limiting attorney's fees and joint and several liability, requiring recognition of collateral sources of compensation, authorizing periodic payments of damages, mandating physician privilege review procedures, authorizing penalties for frivolous suits, encouraging voluntary arbitration, and tightening appellate scrutiny of malpractice verdicts. Moreover, authorized surcharges would, if needed, also provide MMIA with premiums commensurate with its risks—a factor this Court viewed as relevant to the constitutionality of a California scheme to provide automobile insurance by spreading risks among all auto insurers doing business there. *California State Automobile Association v. Maloney*, 341 U.S. 105, 108 (1951). Thus, here, as in *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. at 225-26, the stabilized rates complement "a significant number of provisions . . . that moderate and mitigate" the frequency and severity of claims against MMIA.

Significantly, this Court has repeatedly emphasized the wide latitude which states enjoy to regulate insurance under their police power within constitutional constraints. In upholding the California assigned risk scheme in *Maloney*, the Court rejected the plaintiff insurance association's constitutional objections, 341 U.S. at 109-11, stating:

> The case in its broadest reach is one in which the state requires in the public interest each member of a business to assume a *pro rata* share of a burden which modern conditions have made incident to the business. It is therefore not unlike *Noble State Bank v. Haskell*, 219 U.S. 104, which sustained a state law assessing each state bank for the creation of a depositors' guaranty fund. *What was there said about the police power—that it "extends to all the great*

> *public needs" and may be utilized in aid of what the legislative judgment deems necessary to the public welfare* (p. 111)—*is peculiarly apt when the business of insurance is involved—a business to which the government has long had a "special relation."* See *Osborn v. Ozlin*, 310 U.S. 53, 65, 66. Here, as in the banking field, the power of the state is broad enough to take over the whole business, leaving no part for private enterprise. *Mountain Timber Co. v. Washington*, 243 U.S. 219; *Osborn v. Ozlin, supra*, p. 66. The state may therefore hold its hand on condition that local needs be serviced by the business.
>
> * * *
>
> *Appellant's business may of course be less prosperous as a result of the regulation. That dimunition in value, however, has never mounted to the dignity of a taking in the constitutional sense.* See *Noble State Bank v. Haskell, supra*, p. 110; *Block v. Hirsh*, 256 U.S. 135.

(Emphasis supplied, footnotes omitted).

Similarly, Justice Frankfurther, speaking for the Court in *Osborn v. Ozlin*, 310 U.S. 53 (1940), noted, in rejecting a due process attack, the unique nature of states' regulation of insurance.

> Government has always had a special relation to insurance. The ways of safeguarding against the untoward manifestations of nature and other vicissitudes of life have long been withdrawn from the benefits and caprices of free competition. The state may fix insurance rates, *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389; it may regulate the compensation of agents, *O'Gorman & Young v. Hartford Fire Ins. Co.*, 282 U.S. 251; it may curtail drastically the area of free contract, *National Ins. Co. v. Wanberg*, 260 U.S. 71.

310 U.S. at 65-66 (footnote omitted).

MMIA's taking argument fails because it disregards the essential nature of MMIA, the factual record before the Super-

intendent, and applicable legal standards. Neither MMIA nor its members can point to a statutory or regulatory provision affording it a property interest in any particular rate or even in obtaining a favorable return, and the Court of Appeals correctly concluded that Article 55 did not confer one. *See, e.g., Turnquist v. Elliott*, 706 F.2d 809 (7th Cir. 1983) (no property interest in being paid prevailing wage rate); *Federal Housing Administration v. Darlington, Inc.*, 358 U.S. 84, 91-92 (1958) (no vested right in existing regulatory scheme); *Chicago & Alton Railroad v. Tranbarger*, 238 U.S. 67, 76 (1915). Nothing in the record before the Court of Appeals revealed the impact of the premium rates at issue here on MMIA's members or the rates of return on their investments in the insurance industry. Moreover, nothing in *Brooks-Scanlon Co. v. Railroad Commission*, 251 U.S. 396 (1920), upon which petitioner seeks to draw support, suggests that the significant differences between a proprietary enterprise and MMIA—a non-profit entity created by the Legislature and terminable by the Superintendent, implementing the State's broad police power to foster affordable medical malpractice coverage, with the possibility of MMIA's deficits expressly contemplated in the enabling legislation (Insurance Law §§ 5507, 5509)—should be ignored.

Moreover, as the Court of Appeals correctly observed, Justice Holmes explicitly stated in that very opinion that even commercial enterprises, acting through powers conferred by state charter, may be compelled "to fulfil an obligation imposed by the charter even though fulfilment in that particular may cause a loss." 251 U.S. at 399. Indeed, in *Atlantic Coast Line Railroad v. North Carolina Corporation Commission*, 206 U.S. 1 (1907), the Court upheld such a directive, observing that "as the primal duty of a carrier is to furnish adequate facilities to the public, that duty may well be compelled, although by doing so as an incident some pecuniary loss from rendering such service may result," *id.* at 26. *See also Missouri Pacific Railway v. Kansas ex rel. Railroad Commissioners*, 216 U.S. 262, 279 (1910).

Although MMIA now contends that this rule should only apply when an entity participates in an enterprise voluntarily,

there is no principled basis for such a distinction. The *Atlantic Coast* Court observed that "[a]s the duty to furnish necessary facilities is coterminous with the powers of the corporation, the obligation to discharge that duty must be considered in connection with the nature and productiveness of the corporate business as a whole, the character of the services required, and the public need for its performance." 206 U.S. at 27. The record here reflects that the nature of MMIA is non-profit and that its central purpose is to serve the public interest by assuring a market for medical malpractice insurance. Article 55 of the Insurance Law requires MMIA "to fulfill an obligation" to provide critically needed insurance at the lowest rates possible, even though an actuarially projected deficit may result. The surcharges, however, are expressly designed to satisfy any such deficit without MMIA suffering an actual financial loss. Unlike a company whose investors must absorb deficits resulting from arbitrary rates, therefore, it is MMIA's *customers* who will be required to amortize any deficits resulting from section 40 through the premium surcharges. The Court of Appeals thus correctly concluded that MMIA could be required to fulfill its statutory obligation to offer rates as low as possible without running afoul of the Takings Clause. Moreover, MMIA's members are free to withdraw from MMIA if they regard their participation in it as too burdensome, although they will lose the privilege of writing personal injury insurance within the state as a consequence.

Even in the context of rates for profit-making enterprises, courts have sustained temporary remedial measures that were actually more restrictive than section 40. In *Whitney v. Heckler*, 780 F.2d 963 (11th Cir.), *cert. denied*, 479 U.S. 813 (1986), for example, the Eleventh Circuit upheld a thirty-three month freeze on Medicare rates, enabling Congress to study possible reforms in the Medicare system while the rates were thus stabilized. Significantly, a study of medical malpractice and the many legislative reforms in New York is now ongoing at Harvard University.

Evaluated in this context, it is clear that the rates set by the Superintendent were rationally related to a legitimate state

interest and thus consistent with due process as well. Just as MMIA cannot show a legitimate claim of entitlement to a favorable rate of return in the Insurance Law, so it cannot show any irrationality in the Superintendent's determinations—however unpalatable they may be to MMIA temporarily.

The Superintendent, relying on expert actuaries, had ample warrant to conclude that the rates he set, together with future surcharge income, would provide this non-profit insurer with sufficient premiums to pay claims and expenses, as well as amortize any resulting actuarially projected deficit during the uniquely long period in which MMIA would pay claims. In the interim, these rates were reasonably intended to stabilize otherwise soaring increases in the short term and to permit numerous tort reforms an opportunity to have an impact in the long term. Those are exactly the type of "pragmatic adjustments" which this Court has held an administrator is entitled to make. *Federal Power Commission v. Natural Gas Pipeline Co.*, 315 U.S. 575, 586 (1942).

MMIA's skepticism concerning the wisdom of the tort reforms enacted is irrelevant, given the availability of surcharges to ensure an adequate rate. As this Court established in *Duquesne Light Co. v. Barasch*, 109 S. Ct. at 617, quoting *Federal Power Commission v. Hope Natural Gas Co.*, 320 U.S. 591, 602 (1944), "[i]f the total effect of the rate order cannot be said to be unreasonable, judicial inquiry . . . is at an end." Thus:

> [A]n otherwise reasonable rate is not subject to constitutional attack by questioning the theoretical consistency of the method that produced it. "It is not theory, but the impact of the rate order which counts." *Hope*, 320 U.S., at 602, 64 S.Ct., at 288.

Duquesne Light Co. v. Barasch, 109 S.Ct. at 619. *See also Pennell v. City of San Jose*, 108 S.Ct. 849, 857 (1988). Similarly, MMIA's and AIA's musings concerning the likely ramifications of the Court of Appeals' decision are mere policy arguments and ignore the teaching of this Court that policy is the province of legislatures. *Osborn v. Ozlin*, 310 U.S. at 66.

MMIA has itself adopted an unreasonable position in now seeking to invalidate the one statute that requires any deficit to be fully amortized. The statutory scheme in force from 1975-85 contained no guarantee of an adequate rate. Moreover, the Insurance Law provisions then in effect resulted, MMIA now says, in rates that were all inadequate. Nevertheless, MMIA apparently had no constitutional qualms concerning the prior statute. Indeed, MMIA declined to collect all the increases which were approved.

The provisions in effect from 1975 to 1985 merely gave the Superintendent the power to approve rates that MMIA proposed. The Superintendent now has both the power and the duty to impose surcharges, if the rates for 1985-88 result in actuarially projected deficiencies. Should it be necessary, MMIA can compel the Superintendent to perform his duty by means of an Article 78 proceeding. *See* CPLR § 7801 *et seq.* MMIA is fully familiar with the use of this mechanism having employed it against a prior Superintendent. *See Medical Malpractice Insurance Association v. Lewis*, 112 Misc.2d 103, 445 N.Y.S.2d 1013 (Sup. Ct. N.Y. Co. 1981), *aff'd*, 87 A.D.2d 571, 448 N.Y.S.2d 609 (1st Dept.), *appeal denied*, 56 N.Y.2d 506, 437 N.E.2d 1160, 452 N.Y.S.2d 1025 (1982). The provisions of section 40 accordingly provide MMIA with fuller guarantees of an adequate rate than it enjoyed under the prior statutory scheme.

Not one of the inapposite decisions in the rate-making area on which MMIA relies involved any provision comparable to the mandatory recoupment provision in section 40. Moreover, not one of them involved an instrumentality of the state's police power to regulate insurance and health care, with special public benefit obligations at the core of its creation. As noted above, MMIA is just such an entity.

MMIA's reliance upon *Hartford Accident & Indemnity Co. v. Ingram*, 290 N.C. 457, 226 S.E.2d 498 (1976), to demonstrate a conflict in authority, is misplaced. The question presented in that case was whether the legislature could constitutionally require general insurance companies to offer medical malprac-

tice insurance as a condition of doing business in the State. Neither MMIA nor any of its members has ever challenged the constitutionality of the 1975 legislation creating it, either in this litigation or in any prior proceeding.

Additionally, as noted by a federal court in distinguishing *Hartford Accident*, the challenged legislation there, in contrast to Article 55,

> required all general liability insurers to offer medical malpractice insurance. The statute forced insurers who had previously limited their business to property insurance, to enter the medical malpractice field, and thereby insure a generically different class of risk[;] the Court there based its holding on that ground and expressly left open the issue of whether the Act, if limited to accident and health carriers, would be upheld.

Insurers' Action Council, Inc. v. Markman, 490 F. Supp. 921, 926 (D. Minn. 1980), *aff'd*, 653 F.2d 344 (8th Cir. 1981) (*per curiam*). *See also Health Insurance Association v. Harnett*, 44 N.Y.2d 302, 312, 376 N.E.2d 1280, 1286, 405 N.Y.S.2d 634, 640 (1978). The legislative charter for MMIA is more comparable to the legislation upheld in *California State Automobile Association v. Maloney*, 341 U.S. 105. *See also Prudential Property and Casualty Insurance Co. v. Insurance Commission*, 699 F.2d 690 (4th Cir. 1983); *State Farm Mutual Automobile Insurance Co. v. Whaland*, 121 N.H. 400, 430 A.2d 174 (1981); *Sheeran v. Nationwide Mutual Insurance Co.*, 80 N.J. 548, 404 A.2d 625 (1979).

Finally, in *Hartford Accident*, the court's focus was the impact of the legislation upon the private insurance companies required to participate in the statutory scheme. In this action, in contrast—and contrary to petitioner's belated attempt to assert claims on behalf of its members—the only issue presented is whether section 40 is confiscatory as to MMIA. The Court of Appeals expressly left open the question of the statute's constitutionality as to MMIA members. Thus there is no "special" or "important" reason for this Court to grant the petition.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Dated: New York, New York
May 1, 1989

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APPENDIX

1988 N.Y. Laws, ch. 184, § 19 and ch. 186

§ 1. Section forty of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by a chapter of the laws of nineteen hundred eighty-eight amending the civil practice law and rules and other laws relating to medical, dental and podiatric malpractice, as proposed in legislative bill numbers S. 9065 and A. 11840, is amended to read as follows:

§ 40. The superintendent of insurance shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July first, nineteen hundred eighty-five and ending June thirtieth, nineteen hundred ninety-one. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July first, nineteen hundred eighty-nine, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premiums levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July first, nineteen hundred ninety-one, at which time and thereafter such surcharge shall not exceed [eighteen] *twenty-five* percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. On and after July first, nineteen hundred eighty-nine, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July first, nineteen hundred eighty-five through June thirtieth, nineteen hundred ninety-one policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may

be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section two thousand three hundred three of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice [taken] *enacted or promulgated* in nineteen hundred eighty-five, nineteen hundred eighty-six, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not

any such annual surcharge has been actually imposed as of the establishment of such rates.

§ 2. This act shall take effect on the same date as such chapter of the laws of nineteen hundred eighty-eight takes effect.

Supreme Court, U.S.
FILED
APR 17 1989
JOSEPH F. SPANIOL, JR.
CLERK

(3)

No. 88-1520

IN THE
Supreme Court of the United States
OCTOBER TERM, 1988

MEDICAL MALPRACTICE INSURANCE ASSOCIATION,
Petitioner,
v.
SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,
Respondent.

On Petition for a Writ of Certiorari to the Court of Appeals of the State of New York

BRIEF OF AMICUS CURIAE AMERICAN INSURANCE ASSOCIATION IN SUPPORT OF PETITIONER

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April 17, 1989

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

25 pp

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BRIEF OF AMICUS CURIAE AMERICAN INSURANCE ASSOCIATION IN SUPPORT OF PETITIONER

INTEREST OF AMICUS

The American Insurance Association ("AIA") is a national trade organization representing 204 companies writing property/casualty insurance in every State and jurisdiction of the United States. Together, these companies write more than twenty-seven percent of the total property/casualty premiums written annually and represent over twenty-seven percent of the industry's assets. AIA member companies write over twenty-six percent of the Nation's medical professional liability insurance, the insurance that enables American physicians to safeguard the Nation's health. In addition, AIA member companies employ 130,000 people and are affiliated with 65,000 independent insurance agents nationwide. A substantial number of AIA members are also members of petitioner Medical Malpractice Insurance Association ("MMIA"), and three currently serve on MMIA's board of directors.

AIA's purposes are to promote the legislative and public standing of its members and the insurance industry; to provide a forum for discussion of issues that are of common concern to the property/casualty insurance industry; to keep members informed of regulatory and legislative developments; and to serve the public interest through appropriate activities including the promotion of safety and security of persons and property.

The decision of the New York Court of Appeals in this case is wrong and unfair. Unless corrected, it will have substantial adverse consequences for members of MMIA and, as set forth in Section III of this brief, for the insurance industry and its customers nationwide. AIA is uniquely situated to advise the Court about these far-reaching consequences of the Court of Appeals' decision.

The parties have consented to the filing of this *amicus* brief. Their letters of consent are on file with the Clerk of this Court.

INTRODUCTION

The Court of Appeals has issued an extraordinary ruling, to the effect that the State of New York may 1) create a private entity; 2) compel other private entities to financially support it; and 3) then compel it indefinitely to subsidize a particular class of New York citizens. The Court of Appeals does so by proclaiming, first, that the state-created, privately funded and privately directed entity has no federal rights; and second, that the forced subsidization is legitimate because the State *may*, at some future point, permit the entity to recoup its losses over—at *best*—the course of fifteen years.

Both the Superintendent of Insurance and the Court of Appeals conceded below that the rates set by the Superintendent for the 1985-1988 policy years of petitioner MMIA are inadequate to maintain MMIA solvency unless one considers as "present income" the proceeds of a hypothetical future surcharge that *might* permit MMIA to recoup the losses by the turn of the century at the earliest.

Three important issues of Federal law are therefore presented:

1. May a State create an independent legal entity, compel private corporations to support and operate it, confer on it the rights to own property and to contract, and then cause it to incur large deficits without regard to the constraints of the Fourteenth Amendment?

2. May a State justify an otherwise confiscatory and unconstitutional rate on the theory that it may possibly permit imposition of a surcharge on future rates to recoup the loss?

3. Even assuming it may consider a possible future surcharge in setting present rates, may a State

impose a rate structure that concededly requires the regulated business to operate at a deficit for at least fifteen years?

These legal issues have national importance. The bill for MMIA's huge deficits must, according to statute, be paid by the private insurance companies who are compelled to support MMIA financially, an enormous economic burden for which, in justice, they should not be held responsible. The rules established by the Court of Appeals permit any State, without constitutional limitation, to compel selected companies or individuals to subsidize particular classes of state citizens. Because New York is a bellweather State in the insurance industry, this decision will very likely spawn similar actions with respect to medical malpractice joint underwriting associations ("JUA's") in other States. It gives legitimacy to parochial political pressure to set inadequate rates which impose the costs of expensive services on the national companies that provide those services. And States may create similar schemes to compel private subsidies in other areas of insurance or in other regulated industries. Review is therefore urgently needed.

ARGUMENT

I. The Court of Appeals Incorrectly Held That The State May Compel Private Businesses To Act As Sureties For A State-Created Entity, And Then Confiscate That Entity's Property Without Any Federal Constitutional Constraint.

New York law compels all insurance companies directly writing personal injury liability insurance in the State to be "members" of MMIA, a medical malpractice JUA. N.Y. Ins. Law § 5502(a) (McKinney 1985).[1] It requires assessment of member companies for deficits arising from operations. N.Y. Ins. Law §§ 5503(b), 5507(b)

[1] MMIA's private insurer members elect a majority of MMIA's board of directors, and thus effectively control MMIA's operations. *See* N.Y. Ins. Law § 5508(a) (McKinney 1985).

(McKinney 1985). Although the State created MMIA, and compels private insurers to participate in and underwrite it, New York provides no state funds to support MMIA. New York law compels MMIA to offer substantial medical malpractice insurance coverage[2] upon application by any licensed physician or surgeon, N.Y. Ins. Law §§ 5502(e), 5506 (McKinney 1985 & Supp. 1989); N.Y. Comp. Codes R. & Regs. tit. 11, 70.9(c)(1) (1988) (Twelfth Amendment), yet through rate regulation New York has persistently refused to permit MMIA to charge premiums adequate to offset the liabilities the State compels MMIA to assume. As a result, the State has caused MMIA to incur huge deficits, for which its members are liable, that as of the end of 1985 totalled $80-$85 million on a fully discounted basis.[3] Thus, thanks to inadequate rates, MMIA's members are responsible to underwrite an enormous debt.

By statute, MMIA is a legal entity, separate and distinct from its members. N.Y. Ins. Law § 5502(b) (McKinney 1985). New York law confers on MMIA the power to contract and own property, N.Y. Ins. Law § 5502(b), (e) (McKinney 1985 & Supp. 1989), and, of course, to sue and be sued in its own name.[4]

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[2] Each applicant is "entitled to purchase a policy providing primary limits not to exceed one million dollars for each claimant and three million dollars for all claimants in any one year." MMIA must also offer excess coverage. N.Y. Ins. Law § 5502(e)(1) (McKinney 1985 and Supp. 1989).

[3] According to one study, as of the end of 1987, MMIA's deficit had reached $244,800,000 on a fully discounted basis. R. Kenney, National Coordinating Committee on Medical Malpractice JUAs, 1987 Finanical Condition of Medical Malpractice JUAs at i ("NCC Study"). The Study concluded that MMIA's financial condition is "rapidly deteriorating." *Id.* at ii. *See id.* at 15.

[4] The power to be sued is implicit in the power to enter into contracts of insurance. MMIA maintained the present suit in its own name without any question being raised by the state Attorney General or the New York courts about MMIA's power to do so.

Despite these powers, the Court of Appeals inexplicably ruled that MMIA *has no federal rights* because as "a creature of statute . . . all of [MMIA's] rights, obligations and duties have been defined by the Legislature." *In the Matter of Medical Malpractice Insurance Ass'n v. Superintendent of Insurance*, Cert. Petition, App. A, at 12a-13a (*"MMIA v. Sup't"*). The holding is utterly untenable. This Court has consistently rejected the notion that a State may take away property interests it has created without regard to the procedural and substantive commands of the Due Process and Takings Clauses. The Court has recognized that this theory, that property owners must accept the "bitter with the sweet," would effectively undermine *all* constitutional protection for private property. *See Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 540-41 (1985) ("the 'bitter with the sweet' approach misconceives the constitutional guarantee. . . . The right to due process 'is conferred, not by legislative grace, but by constitutional guarantee.' "); *Webb's Fabulous Pharmacies, Inc. v. Beckwith*, 449 U.S. 155, 163-64 (1980) (rejecting State's claim that because it required private entities to contribute to a fund, State was entitled to the interest earned by the fund; "a State, by *ipse dixit*, may not transform private property into public property without compensation"). Having recognized that MMIA has traditional property rights such as the right to own property and to contract, the State simply may not appropriate MMIA's property without compensation, or without affording due process,[5]

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[5] This Court's decision in *Webb's Fabulous Pharmacies* precludes the Court of Appeals' holding in the instant case. There, the State required certain private parties to an interpleader action to pay funds into court for eventual distribution to the funds' rightful, and as yet undetermined, owner. By statute, the State provided that the interest earned by the fund, while held by the court, belonged to the State. Once deposited, the funds were considered "public money," and the Florida courts upheld the statute on the theory—indistinguishable from the New York court's theory here—that "the statute takes only what it creates": under state law the fund belonged to the State, not any private party. *Webb's Fabulous*

on the theory that this privately supported and operated association was "a statutory entity created by the legislature." *MMIA v. Sup't*, Cert. Petition at 13a.

To the contrary, in 1987, this Court made clear that an entity chartered by Congress is *not* a government agent, but a private actor. *San Francisco Arts & Athletics v. Olympic Comm.*, 107 S. Ct. 2971, 2985 (1987). The Court observed that "[a]*ll* corporations act under charters granted by a government, usually a State. They do not thereby lose their essentially private character." *Id.* (emphasis added). Nor, therefore, do they lose their constitutional rights. *See generally First National Bank of Boston v. Bellotti*, 435 U.S. 765, 778-80 n. 14 (1978).[6]

Pharmacies, 449 U.S. at 158-59. This Court struck down the State's appropriation of the interest on this fund, holding that a State may *not* define away the customary, constitutionally protected incidents of property ownership, which are protected from confiscation by the Takings Clause. *Id.* at 164.

[6] The cases relied upon by the Court of Appeals stand for the opposite propositions from those for which they were cited. In *Brooks-Scanlon Co. v. Railroad Comm'n*, 251 U.S. 396 (1920), this Court articulated the special rule, irrelevant here, that where an entity *contracts* in its charter to do an act, as long as it chooses to operate under the charter it can be held to that commitment notwithstanding the fact that it later proves impossible to perform it at a profit. *Id.* at 399. But Brooks-Scanlon made clear that the imposition of rate-ceilings that guaranteed that the entity would sustain a loss was unconstitutional: "[a] carrier cannot be compelled to carry on even a branch of business at a loss, much less the whole business of carriage. . . . The plaintiff [cannot] be compelled . . . to maintain a railroad for the benefit of others who do not care to pay for it." *Id.* And in *Missouri Pacific R.R. Co. v. Kansas*, 216 U.S. 262, 278 (1910), and *Atlantic Coast Line R.R. Co. v. North Carolina Corp. Comm'n*, 206 U.S. 1, 26 (1907), this Court clearly distinguished between a contractual duty to perform an obligation even if no profit can be realized as a practical matter —which may be enforced without offending Due Process—and rate regulation that on its face denies just and proper remuneration. Because the instant case involves a legislative scheme that compels MMIA to write insurance and fixes rates that concededly impose a substantial deficit, each of the cases relied upon by the court below actually undercut its holding.

Similarly, despite the Court of Appeals' suggestion it is irrelevant that "MMIA is a nonprofit unincorporated association." *MMIA v. Sup't*, Cert. Petition at 13a. Nonprofit entities, *see, e.g., Riley v. National Federation of the Blind*, 108 S. Ct. 2667 (1988) (permitting constitutional challenge by non-profit groups); *FEC v. Massachusetts Citizens for Life*, 107 S. Ct. 616 (1986) (same), and unincorporated associations, *see, e.g., California State Auto. Ass'n Inter-Insurance Bureau v. Maloney*, 341 U.S. 105, 108 (1951) (due process challenge by unincorporated insurance association); *Help Hoboken Housing v. City of Hoboken*, 650 F. Supp. 793, 795 (D.N.J. 1986) (takings clause challenge by unincorporated association), possess constitutional rights including the rights to due process of law.

Nor is MMIA deprived of constitutional rights because it is highly regulated. *Compare MMIA v. Sup't*, Cert. Petition at 12a-13a. It is well-established that the power to regulate even a highly regulated industry does *not* confer the power to disregard the Due Process or Takings Clauses. *See Duquesne Light Co. v. Barasch*, 109 S. Ct. 609, 615 (1989); *Consolidated Edison Co. v. Public Service Comm'n*, 447 U.S. 530, 535, n. 1 (1980); *Atlantic Coast Line R.R. Co. v. North Carolina Corp. Comm'n*, 206 U.S. 1, 20 (1910). As recently as January, this Court made clear that a public utility, whose "assets are employed in the public interest," is protected by the Constitution "from being limited to a charge for [its] property serving the public which is so 'unjust' as to be confiscatory.'" *Duquesne Light Co. v. Barasch*, 109 S. Ct. at 615.

At bottom, the Court of Appeals' decision was a transparent, result-oriented attempt to avoid ruling on the due process issue presented: whether the Superintendent's deliberate setting of rates inadequate to maintain MMIA's solvency was "confiscatory" as a matter of federal law. Its ruling would permit States to confiscate the property of all state-created and state-regulated private entities at will.

II. This Case Squarely Presents An Important Issue Of Federal Law Left Open In *Duquesne Light Co. v. Barasch:* Does The Fourteenth Amendment Prohibit The State From Setting Rates Even It Must Concede Render A Regulated Entity Insolvent, On The Theory That The State *May,* In Subsequent Years, Institute A Compensatory Rate Increase.

In *Duquesne Light Co. v. Barasch,* 109 S. Ct. 609 (1989), this Court ruled that although no particular *method* of rate-making is constitutionally required, rate-making with a confiscatory *impact* is unconstitutional. *Id.* at 617-619; *id.* at 620 (Scalia, J., concurring, joined by Justices White and O'Connor). As Justice Scalia observed, "the Constitution . . . looks to the *consequences* a governmental authority produces rather than the techniques it employs." *Id.* (emphasis added). *This* case squarely presents a challenge to the *consequences* of New York's rate-regulation: the State *admits* that the rates it imposed are inadequate to maintain MMIA's solvency. The issue presented is whether New York may do so on the theory that sometime in the *future* it may—but is not obligated to—authorize a surcharge sufficient to recoup losses sustained by MMIA under the present rates.

The parties are in agreement that "without . . . consideration of future surcharges," the rates set for MMIA by the Superintendent for policy years 1985-1988 "are entirely inadequate to meet the statutory standards of solvency under the Insurance Law." *MMIA v. Sup't,* Cert. Petition at 5a.[7] The Court of Appeals agreed, *id.,* holding that New York law *requires* the Superintendent to consider these merely *possible* future surcharges as if they were presently "income earned," *id.* at 8a, thereby assuring that present rates will be inadequate to cover liabilities presently assumed.

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[7] New York insurance law defines insolvency in relevant part as inability "to pay . . . outstanding lawful obligations as they mature in the regular course of business, as shown by an excess of required reserves and other liabilities over admitted assets." N.Y. Ins. Law § 1309(a) (McKinney 1985).

It is indisputable there can be no guarantee the Superintendent will authorize adequate future surcharges; indeed they may well prove to be illusory.[8] The Court of Appeals conceded that the present rates were based only on "the *assumption*" of "the Superintendent's *willingness* to permit 'adequate' increases beginning in 1988-1989 and the following years." *Id.* at 10a (emphasis added).

The Court of Appeals further conceded that—even assuming substantial future "surcharges" would be put into effect —"MMIA may well be forced to run at a deficit until the surcharges result in recoupment in approximately the year 2000." *Id.* at 11a. Thus, even if the Superintendent and the state legislature find the will to permit MMIA to charge the substantially above-cost (up to 25%) future surcharges counted as "present income" by the Superintendent when calculating the 1985-1988 rates, it is uncontested in this record that MMIA will be forced to carry liabilities for policy years 1985-1988 significantly in excess of its assets *for more than a decade.* See *id.* at 10a. Because the Superintendent has not shown any inclination to allow MMIA to charge rates adequate to offset liabilities currently incurred—much less rates twenty-five percent above that level—it is clear that New York

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[8] The statute as most recently amended provides that "the Superintendent shall impose a surcharge on premiums" to recoup a projected deficit. But the statute makes clear that the Superintendent's action may take place sometime "on *or after*" July 1, 1989, not to *exceed* eight percent of the established rate until July 1, 1991, "at which time and thereafter such surcharge shall not *exceed* twenty-five percent" of the approved rate. N.Y. Laws. ch. 186, § 1 (McKinney 1988) (emphasis added). The law sets no time-table within which deficits must be recouped. Thus, although arguably the Superintendent must institute *some* surcharge at *some* time, apparently he may institute it whenever he wishes, and may set it at a level down to 1 percent or lower in his sole discretion. Furthermore, the surcharge would be expressed as a percentage of rates in future premium-years, and its effectiveness in recouping prior deficits would plainly turn on whether those future rates were themselves adequate to offset the liabilities assumed in each future premium-year. An adequate surcharge can therefore be seen only as merely *possible* at best.

may *never* permit MMIA to charge a rate sufficient to meet the liabilities it is statutorily compelled to assume.[9] Moreover, even if the Superintendent permits a facially adequate surcharge, there is no guarantee it will be effective; many doctors faced with a choice of paying rates twenty-five percent above adequate levels or self-insuring or seeking alternative risk-spreading devices will almost certainly stop purchasing insurance subject to the surcharge. Without customers willing to pay rates bloated by the surcharge, the authority to include a surcharge in future rates may be of no value to MMIA. Thus, there is substantial doubt that New York will ever truly permit MMIA to recoup the losses it has been forced to sustain in the period at issue.

In the insurance industry, as in all others, it is essential that rates be sufficient to offset the costs of providing the product at issue. An insurance company's "product" is the assumption of the customer's potential liabilities during the term of coverage. Responsible pricing of the insurance product ensures that current assets and anticipated earnings thereon will offset the projected liabilities assumed based upon actuarially sound predictions. *See, e.g.*, R. Mehr & E. Cammack, Principles of Insurance

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[9] Indeed, the Court of Appeals' hypothetical future surcharge theory would permit the State to play an escalating deficit "shell game" with devastating results. The New York Insurance Department in a recent statutorily-mandated report to the Governor and Legislature conceded that MMIA has been compelled to charge inadequate rates in every year of its existence. N.Y. Ins. Dept., *A Balanced Prescription for Change: Report of the New York State Insurance Department on Medical Malpractice* 73-74 (1988). Nothing would stop the Superintendent from authorizing a surcharge on inadequate future rates, thereby perpetuating the deficit. Any surcharge applied to inadequate rates will not return sufficient capital to eradicate MMIA's enormous 1985-88 deficit even by the year 2000. Moreover, the Superintendent could designate 25% of an inadequate future rate as a "surcharge"—thereby allegedly "recouping" past deficits while generating truly staggering *future* deficits. The possibility the State could play this "shell game" until MMIA collapses highlights the absurdity of permitting rates to be set on the basis of hypothetical future "surcharges."

789-90 (1967); C. Kulp & J. Hall, Casualty Insurance 772-76 (1968). If they are not, a company will become insolvent, even if there is sufficient cash-flow to pay claims that come due today. *See* N.Y. Ins. Law § 1309 (McKinney 1985). Adequate rates (those that maintain solvency) are essential to avoid insurance company failure when the assumed liabilities mature. R. Mehr & E. Cammack, *supra*, at 789.

New York's insistence that MMIA charge rates that do not maintain solvency poses two important questions about constitutional limits on rate-making: *First*, may the State fix rate-ceilings that concededly prevent a company from retaining assets sufficient to offset liabilities the State compels it to assume on the theory that the State *might*, at some future time, permit the company to charge a substantially higher price? *Second*, may the State fix rate-ceilings that—even under the rosiest of scenarios—will require the company to wait more than a decade to recoup the deficits thereby imposed? These important issues are squarely within the zone of legitimate constitutional challenges to rates identified in *Duquesne Light*—challenges to the confiscatory *impact* of state-set rates.

As to both questions, the Court of Appeals' decision was radically at variance with principles announced in this Court's precedents and the decisions of lower courts. This Court has repeatedly held that if a State chooses to fix the rates at which private entities may offer their services, those rates must be just and reasonable, and cannot be set so low as to be confiscatory. *Id.* at 615; *Federal Power Comm'n v. Texaco, Inc.*, 417 U.S. 380, 391-92 (1974); *Federal Power Comm'n v. Hope Natural Gas Co.*, 320 U.S. 591, 602 (1944). And although the determination of what is a "fair rate of return" may vary from case to case depending upon "the risks under a particular rate-setting system, and on the amount of capital upon which the investors are entitled to earn that return," *Duquesne Light Co.*, 109 S. Ct. at 617, in *no* case

can it be "reasonable" or "just," *see id.*, to fix a rate that mandates operation at a deficit for a prolonged period of time.[10] In *Hope Natural Gas Co.*, this Court made clear that a state-set rate is confiscatory if its "total effect" fails to return "not only . . . operating expenses but also . . . the capital costs of the business." 320 U.S. at 602-603. Indeed, no more straightforward definition of a "confiscatory" rate could be advanced than one that compels the seller to take less in payment than his cost for the product.

Use of a merely possible—perhaps even nonexistent—future price increase to justify rates that are otherwise presently confiscatory violates the most basic tenets of due process. As long ago as 1935, Justice Cardozo made clear that "[p]resent confiscation is not atoned for by merely holding out hope of a better life to come." *West Ohio Gas Co. v. Public Utilities Comm'n*, 294 U.S. 79, 83 (1935). Similarly, in *Mora v. Mejias*, the First Circuit rejected the notion that the State may fix a price-ceiling

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[10] *See Mora v. Mejias*, 223 F.2d 814, 818 (1st Cir. 1955) ("it is well settled that it is a deprivation of property without due process of law for a state to compel a public utility to continue to operate at a loss"); *Aetna Casualty & Surety Co. v. Commissioner*, 358 Mass. 272, 281, 263 N.E.2d 698, 703 (1970) (State "may not constitutionally fix rates which are so low that if insurers engage in business they may do so only at a loss"); *Jordan v. American Eagle Fire Ins. Co.*, 169 F.2d 281, 289 (D.C. Cir. 1948) (insurance rates must be set so as to provide "enough revenues for operating expenses, capital costs, and sufficient return to the equity owner to assure financial integrity of the enterprise, so as to maintain its credit and to attract capital"), *citing Federal Power Comm'n v. Hope Natural Gas Co.*, 320 U.S. 591 (1944); *Isla Petroleum Corp. v. Department of Consumer Affairs*, 640 F. Supp. 474 (D.P.R. 1986) (holding unconstitutional certain rates because the "scene is set to force the plaintiffs to operate losing money until the defendant evaluates the matter later this year"), *aff'd on other grounds*, 811 F.2d 1511 (Temp. Em. Ct. 1986), *rev'd on other grounds*, 108 S.Ct. 1350 (1988); *Brooks-Scanlon Co. v. Railroad Comm'n*, 251 U.S. at 399 ("[a] carrier cannot be compelled to carry on even a branch of business at a loss, much less the whole business of carriage").

that requires a regulated entity to sustain a present loss on the theory that the costs of providing the product *might* later diminish, thereby permitting the entity to recoup its losses. 223 F.2d at 819. A rule permitting presently confiscatory rates based on a mere possibility of future recoupment would give States *carte blanche* to impose losses on rate-regulated industries, thereby forcing them to subsidize their customers. *See generally id.* at 818 (it is unconstitutional for government to "deliberately set out to subsidize . . . consumers at the expense" of the regulated entity). *Any* price—even a forced giveaway—could be justified on the theory that the State *might* someday authorize a huge price increase.[11]

Moreover, New York's actions here are insupportable even if the State *may* in theory rely upon its possible future surcharges to justify present rates. By the Court of Appeals' and the Superintendent's own concession, under the most optimistic scenario considered when these rates were set, "the deficit caused by the 1985-1988 rates could be cured by approximately the year 2000." *MMIA v. Sup't*, Cert. Petition at 10a; *see id.* at 11a. It has long been established that compelled operation at a deficit for any significant period of time is a confiscatory violation of due process. No court of which *amicus* is aware has sanctioned a period of mandated losses even close to the twelve to fifteen years contemplated here.[12]

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[11] The Superintendent's rosy conjectures about the possible effects of tort reform on the projected deficits are similarly insufficient to justify rates that are presently confiscatory. *See West Ohio Gas Co. v. Public Utilities Co.*, 294 U.S. at 83; *Mora v. Mejias*, 223 F.2d at 819.

[12] *See, e.g., Newton v. Consolidated Gas Co. of New York*, 258 U.S. 165, 175 (1922) (holding that company was entitled to relief where the prescribed rate had yielded no fair return for more than a year); *Smith v. Illinois Bell Telephone Co.*, 270 U.S. 587, 591 (1926) ("[p]roperty may be as effectively taken by long-continued and unreasonable delay in putting an end to confiscatory rates as by an express affirmance of them"; lack of action for five years was unconstitutional taking); *Bluefield Improvement Co. v. Public*

This matter therefore offers an important opportunity for this Court to give content to the as-yet undefined constitutional "margins" of state rate-setting authority alluded to in *Duquesne Light*. *See* 109 S.Ct. at 617.

III. The Court Of Appeals' Decision Is Unfair And Dangerous; It Invites States To Solve Fiscal And Policy Problems By Shifting The Cost Of Liability Insurance From The Beneficiary Or The State, Where It Properly Belongs, To The Insurer.

"It is axiomatic that the Fifth Amendment's just compensation provision is 'designed to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole.'" *Pennell v. City of San Jose*, 108 S. Ct. 849, 856 (1988) (citation omitted). New York's actions in this case, initiated by its legislature and carried out by its Superintendent and Court of Appeals, are designed to force insurers to underwrite the cost of medical malpractice insurance, thereby solving two public problems for which those insurers are in no sense responsible: the

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Service Comm'n, 262 U.S. 679, 690 (1922) ("Rates which are not sufficient to yield a reasonable return on the value of the property used at the time it is being used to render the service are unjust, unreasonable, and confiscatory, and their enforcement deprives the public utility company of its property in violation of the Fourteenth Amendment."); *Prendergast v. New York Tel.*, 262 U.S. 43, 49 (1922) (deprivation of fair rate of return for seven months held confiscatory).

In *Federal Power Comm'n v. Hope Natural Gas Co.*, 320 U.S. 591 (1944), this Court abandoned the detailed review of *methodology* involved in the early rate-setting cases. But this Court has never abandoned the principle—implicit in the Takings and Due Process Clauses—that there is some price below which the State may not compel a merchant to sell. *Id.* at 603. Nor has the Court abandoned the propositions, implicit in this concept, that a rate-setting board may not ask a seller to look to the sale of future products to offset mandated present sales at confiscatory rates, or that a business cannot be forced to wait an extended period of time before it may charge rates that permit it to break even.

fiscal crisis in which most governments—federal, state, and local—presently find themselves, and the high costs imposed on society by medical malpractice. The former is the result of excess government spending or insufficient taxation for which the legislature itself is responsible. The latter is the result of the number and severity of the medical malpractice actions filed against physicians, hospitals and other health care providers. There is no contention in this case that MMIA's deficit is in any degree caused by MMIA's own inefficiency or other default, or that of any other insurance company.

The obvious effect of compelling MMIA to run a deficit for decades at a time—with private insurers compelled to underwrite the deficit—is to threaten MMIA's members with substantial losses, totalling many millions of dollars, while saving doctors a like sum in subsidized malpractice insurance. Although insurer-members of MMIA may seek to pass that enormous cost along to their customers, there are severe constraints on their ability to do so. Insurance is a highly competitive business, and competitive pricing will severely limit MMIA's members' ability to include the high costs of MMIA membership in the rate base of MMIA members' property, casualty, and other insurance policies.[13] Moreover, any attempt by

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[13] The competitiveness of the property and casualty insurance industry in New York and the current market condition of property and casualty insurance will make it difficult for companies to recoup through rate increases any assessment that they will be forced to pay. In 1987, for example, there were 287 companies writing property and casualty insurance in New York. *Best's Executive Data Service*, Report A2, A.M. Best Company, Inc., 1988. The leading four companies had only 25.6 percent of the insurance market, well below the 60 percent market share standard that is commonly accepted as indicating a potentially non-competitive market. The leading eight companies had only 41.6 percent of the market, again well below the 80 percent standard commonly accepted as a sign of non-competitiveness. Moreover, no single company had more than 7.4 percent of the market. *See Best's Market Share Reports*, 1988 (market share numbers); Tillinghast, Nelson

MMIA member-insurers to recoup an assessment through high rates would prompt swift entry into the market by new or established companies previously not doing business in New York. Such new or potential entrants in the New York market, able to set rates without regard to prior assessments, would prevent MMIA members from charging significantly higher rates to recoup those prior assessments.[14] And doctors may choose to self-insure or seek other risk-spreading devices rather than pay extraordinarily high rates. Competitive forces, therefore, will assure that the loss will largely be concentrated on MMIA member-insurers.[15]

Nor would the unconstitutional and unfair effect of New York's actions be ameliorated even if MMIA's members *could* spread a significant part of the burden to their customers. Such spreading would merely change the *source* of the subsidy to the doctors insured by MMIA, not the fact of state-compelled private subsidization. Any customer of one of MMIA's member companies forced to pay higher insurance premiums to offset MMIA's stag-

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& Warren, Inc., *Report to Vermont Department of Banking and Insurance*, December 4, 1986 (describing market-share standards).

[14] Because new companies will not have been subjected to the assessment, they will have a competitive advantage over existing firms in the New York insurance market. Capital and surplus requirements are low in the insurance industry, and fixed asset requirements consist primarily of home office, branch office, and computer facilities. These can be bought, leased, or rented on short notice. Of course, for existing insurance companies expanding into a new State, these entry barriers would be even lower since they already possess home office and computer facilities.

[15] If the Superintendent were to declare MMIA insolvent, claims of MMIA's insureds would become the responsibility of the Property/Casualty Insurance Security Fund, which is in turn funded through assessments of all property and casualty insurers writing policies in New York. N.Y. Ins. Law § 7603 (McKinney 1985 and Supp. 1989). The Superintendent thus has the authority to compel all property and casualty insurers in the State to make good on the underfunded commitments MMIA is presently required to make.

gering losses would be subsidizing the doctors entitled to purchase malpractice insurance at MMIA's subsolvency rates. Mandating this subsidy of MMIA's customers by customers of MMIA's member companies is not fairer than requiring the member-insurers to bear the burden alone.

Just such an unfair compelled private subsidy underlies the "future surcharge" approach taken by the Superintendent and the Court of Appeals: even if the Superintendent *does* approve the future surcharge, the costs of medical malpractice policies for doctors *currently* insured will merely be shifted unfairly to *future* doctors. Current and future doctors are *not* identical; doctors enter practice, leave practice, change States, change insurers, and, in some cases, choose to self-insure.

Moreover, competitive conditions will almost certainly doom the planned "recoupment" through a future surcharge precisely because requiring this subsidy of present doctors by future doctors *is* unfair. The premise of New York's decision to compel MMIA to write insurance at below cost has been that rates that would have permitted MMIA to break even would have also "discourag[ed] physicians and dentists from initiating or continuing their practice in New York." Medical Malpractice Reform Act of 1986 (L 1986, ch 266), Section 1, quoted in *MMIA v. Sup't*, Cert. Petition, App. C., at 18a. A dramatic rise in MMIA's rates in the nineteen nineties—to surcharge-enhanced levels of up to twenty-five percent above an "adequate" rate—would surely create as much discouragement as would the at-cost rates rejected by the State in 1985. Rates twenty-five percent above rates adequate to offset future losses would certainly induce many doctors who would otherwise purchase malpractice insurance through MMIA instead to self-insure or to seek alternative risk-spreading devices. Desertion of MMIA by its customers would prevent MMIA from *ever* recouping the losses New York is presently imposing on

it, even if the Superintendent *did* elect to authorize a high surcharge.

If the holding of the Court of Appeals is permitted to stand, it will have a particularly adverse impact upon the medical malpractice insurance industry nationwide. By the end of 1987, thirteen medical malpractice JUAs, including New York's MMIA, had been created by twelve States and Puerto Rico, *see* NCC Study at 1, and all thirteen *required* private insurers to be members of the association as a prerequisite to writing insurance in the State. *See generally* NCC Study. Five of the thirteen JUAs had a market share in 1987 above 45% of the market for malpractice insurance in their particular States. NCC Study at 31.[16] Four of the five were operating at a deficit at the close of 1987, the most recent year for which authoritative data are available.[17]

Eleven medical malpractice JUA States permit or require assessment of insurers in the event the JUA operates at a deficit and is unable to pay claims against it.[18]

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[16] The market shares of certain medical malpractice JUAs for 1987 were as follows: Florida, 10.4%; Kansas, 5.9%; Massachusetts, 84.5%; Minnesota, 0.4%; New Hampshire, 52.5%; New York (MMIA), 14.3%; Pennsylvania, 3.4%; Rhode Island, 75.1%; South Carolina, 53.7%; Texas 9.9%; Virginia, 2.8%; Wisconsin, 46.8%. NCC Study at 31.

[17] The deficits for these four JUAs, after taking into consideration investment income, were estimated as follows: Massachusetts, $430,000,000; New Hampshire, $700,000; Rhode Island, $74,000,000; and South Carolina, $4,800,000. NCC Study at i. MMIA's $244,800,000 discounted deficit as of the end of 1987 was among the very highest in the Nation, *see id.*, despite its relatively small share of New York's market. Although some might argue that tort reform and other developments may have moderated the level of certain of these deficits, New York's assertion of the power to impose such deficits virtually at will threatens reescalation of such debt at any time.

[18] Texas has already assessed insurers for the deficit of its joint underwriting association. NCC Study at i. Texas assessed insurers in 1985 and 1986. *Id.* at 24.

Id. at 1. If the decision below is allowed to stand, nothing will prevent all ten of the other States from shifting the costs of medical malpractice insurance to members of their JUAs just as New York has done. Insurance companies impressed as "members" of those JUAs would then be compelled to underwrite truly eye-popping deficits. *See* n. 16, *supra*. The ruling permits state legislatures to underprice privately-written insurance as a political solution to the high cost of medical malpractice. Indeed, if the decision of the Court of Appeals is not reversed, nothing will prevent the remaining forty States from adopting a similarly "convenient" solution to medical malpractice and fiscal problems of their own without recourse to increased spending and higher taxes.

The Court of Appeals' decision could also affect types of insurance other than medical malpractice. Many similar plans or insurance pools in other casualty insurance areas—such as automobile insurance [19] and workers' compensation [20]—are generating deficits in many States. And New York's compelled-private-subsidy mechanism could be employed even outside the field of insurance, requiring public utilities or petroleum companies, for example, to subsidize their customers over extended periods of time.

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[19] Automobile Insurance Plans Service Office, AIPSO Facts 1987/1988: A Handbook of Auto Shared Market Facts and Figures at 8. Of the more than 127 million passenger cars insured in the United States, 7.8 million receive insurance through shared market mechanisms. *Id.* at 12. Every State has a shared market mechanism, and 42 jurisdictions have automobile insurance plans. *Id.* at 8. The plans of several States are generating large deficits. *See, e.g., An Evaluation of the Massachusetts Automobile Insurance Market, With Recommendations for Change*, Prepared for the American Insurance Association by Goldstein & Manello (Nov. 1988) (Massachusetts); N.Y. Times, Aug. 7, 1988, at 33 (New Jersey).

[20] Reinsurance pools for workers' compensation have been created in 41 States. The National Council on Compensation Insurance, Management Summary for 1987 on Workers Compensation Reinsurance Pools at 11 ("NCCI Study").

CONCLUSION

This Court must review the Court of Appeals' extraordinary assertion of state power to confiscate and redistribute property.

Respectfully submitted,

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April 17, 1989

Supreme Court, U.S.
FILED
MAY 5 1989
JOSEPH F. SPANIOL, JR.
CLERK

No. 88-1520

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

MEDICAL MALPRACTICE INSURANCE ASSOCIATION,

Petitioner,

v.

SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

REPLY BRIEF FOR PETITIONER

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

No. 88-1520

MEDICAL MALPRACTICE INSURANCE ASSOCIATION,

Petitioner,

v.

SUPERINTENDENT OF INSURANCE OF THE STATE OF NEW YORK,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

REPLY BRIEF FOR PETITIONER

The petitioner, Medical Malpractice Insurance Association ("MMIA"), respectfully submits this reply brief to Respondent's Brief in Opposition to Petition for Writ of Certiorari.

I.

The Holding of the Court Below That An Insurer May Be Compelled to Operate at a Loss Requires Immediate Review by This Court

The New York Court of Appeals now has made clear that this case involves a novel interpretation of federal constitutional law, which requires immediate review by this Court. In *Medical Malpractice Insurance Association v. Cuomo*, No. 88, slip op.

(N.Y. May 2, 1989), the New York Court of Appeals rejected MMIA's constitutional challenge to a retroactive taking of funds held by MMIA. In a memorandum opinion, a copy of which is annexed as Appendix A to this reply brief, the court stated as follows:

> We have recently determined that the Legislature may require the Medical Malpractice Insurance Association (MMIA) to operate at a loss on a temporary or even continual basis in order to promote affordable medical malpractice coverage.

(App. A at 2a)[1] (citation omitted).[2]

Thus, the issue squarely presented to this Court is whether, as the court below has held, a state can compel an insurer, which is privately funded and controlled, to operate at a loss—even on a "continual basis"—for the benefit of a particular group of policyholders within the state. All other reported decisions upholding state-created joint underwriting associations ("JUA's"), such as MMIA, uniformly have required that the rates charged by the JUA be adequate, reasonable and not confiscatory (*see* MMIA's Petition for a Writ of Certiorari to the Court of Appeals of the State of New York ("Petition") at 16-17, 21).

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1 Parenthetical references to "App." are to the Appendix to this reply brief or to the Petition where indicated. Parenthetical references to "A." are to the Appendix of the Superintendent in the proceedings below. Parenthetical references to "RA." are to the Appendix by MMIA in the proceedings below.

2 In *Cuomo*, a New York law retroactively required MMIA to refund over $10 million which it had lawfully collected and applied to its deficit. The Court of Appeals reversed two lower court decisions sustaining MMIA's assertion of an unconstitutional taking against a motion to dismiss by the State, holding as follows:

> As a creature of statute, MMIA had no vested property interest in those charges and it was within the Legislature's prerogative to direct a refund in an effort to reduce overall health care costs.

(App. A at 2). Consequently, MMIA's $85 million deficit as of December 31, 1985, which is cited in MMIA's Petition for a Writ of Certiorari, at page 4, is now retroactively increased by an additional $10 million.

The New York Court of Appeals alone has erroneously departed from this Court's long-established and consistent teaching that the fifth and fourteenth amendments forbid confiscatory state-prescribed rates (*see* Petition at 13-19).

The Superintendent's contention that the issue is not ripe for review by this Court is ludicrous. Since July 1, 1985, he has set grossly inadequate rates for MMIA's operation. The rates do not enable MMIA to pay its normal operating expenses, including the setting aside of reserves for losses and loss adjustment expenses that will arise under the policies that it is mandated to issue. The risk of professional liability losses and expenses is being shifted from physicians to MMIA upon payment of only a fraction of the costs of such losses and expenses. MMIA is presently forced to assume contractually the full burdens of physicians' loss and expense obligations upon the fiction that the resulting deficits will be recouped from future generations of policyholders. As the court below recognized, even if the recoupment scheme were to work, the calculations of the Superintendent's own actuary showed that MMIA's deficit caused by the 1985-1988 rates cannot be cured until at least the year 2000. *Medical Malpractice Ins. Ass'n v. Superintendent of Ins.*, 72 N.Y.2d 753, 765 (1988) ("*MMIA v. Superintendent*") (Petition, App. A at 10a).

The uncontroverted evidence in the record establishes that MMIA has incurred, and continues to incur, whopping deficits under the rates upheld by the New York Court of Appeals. Under the Superintendent's theory, MMIA would be without constitutional recourse until even larger deficits have accrued and it has become clear, some years in the future, that the deficits cannot be recouped (*see* Respondent's Brief at 8-12).[3]

This Court appropriately has rejected similar ripeness contentions. In *Blanchette v. Connecticut General Ins. Corps.*, 419

3 By the time it is clear that the surcharges cannot recoup the deficits, the Superintendent likely will have become MMIA's liquidator. It is doubtful that he then will bring an action against himself for having failed to set adequate rates, as suggested at page 11 of Respondent's Brief.

U.S. 102 (1974). Justice Brennan, writing for the majority, cogently stated as follows:

> Where the inevitability of the operation of a statute against certain individuals is patent, it is irrelevant to the existence of a justiciable controversy that there will be a time delay before the disputed provisions will come into effect. "One does not have to await the consummation of threatened injury to obtain preventive relief. If the injury is certainly impending that is enough."

Id. at 143 (*quoting Pennsylvania v. West Virginia*, 262 U.S. 553, 593 (1923)) (citations omitted).

Pennell v. City of San Jose, 108 S. Ct. 849 (1988) does not support the Superintendent's ripeness argument in the present case (Respondent's Brief at 10). In *Pennell*, this Court rejected a taking claim as premature because there was no evidence in the record that the statutory provision under challenge had even been relied on by the agency in making its determination.

The Superintendent's assertion that he has never conceded that the rates are inadequate (Respondent's Brief at 9) is belied by Section I of the opinion of the court below, which the Superintendent has adopted as his statement of the case (*id.* at 3). Section I of the opinion states, in pertinent part, as follows:

> Both parties agree that without this consideration of future surcharges, both the primary and the two excess layers of insurance are entirely inadequate to meet the statutory standards of solvency under the Insurance Law (*see*, Insurance Law §§ 5505, 2303).

MMIA v. Superintendent, 72 N.Y.2d 753, 759; (Petition, App. A at 5a).

The Superintendent erroneously asserts that the annual deficits arising from the post-July 1, 1985 inadequate rates have not yet been actuarially projected (Respondent's Brief at 9, 12). In fact, the uncontroverted testimony of the actuaries at the hearing established that the total deficits of the two major New York medical malpractice insurers for the three policy years

1985 through 1988 would be at least $1.6 billion (A. 1197-98, 1221-22, 1283, 1287; *see also* A. 314, 961). The Superintendent's actuary testified that the total deficits arising from the primary rates alone likely would be at least $1.386 billion based on the "scenario" calculations that he had performed for the Superintendent (A. 1197-98, 1221-22). The undisputed testimony of MMIA's actuary shows that the annual deficit accruing to MMIA is almost $80 million (A. 1030). The actuaries' projections took into account the potential beneficial effects of the "tort reform" legislation (RA. 88, A. 1000).

The statutory scheme of future surcharges in no way "guarantees" that the current rate deficiencies will be recouped (*see* Respondent's Brief at 10, 12, 19). If physicians will leave the state or "go bare" when confronted with substantial premium increases—as the Superintendent has reported to the Governor and Legislature (*see* Petition at 9 n.11)—then, manifestly, there will be no future policyholders to pay the surcharges. Furthermore, the Superintendent failed to bring about a condition precedent to the scheme for recoupment of the deficits through future surcharges. Rates were not brought to adequate levels commencing July 1, 1988, as the Superintendent's actuary had testified would be necessary (Petition at 8 n.10). Although the court below recognized that the condition precedent was part of the actuary's recoupment assumptions, *MMIA v. Superintendent*, 72 N.Y.2d at 764 (Petition App. A at 10a-11a), it failed to recognize that the condition had not occurred.

The trial court appropriately found, based on the evidence adduced, that the statutory scheme for recoupment "depends upon future results which themselves rest on a speculative foundation with no basis in past experience." (Petition, App. D at 34a). The scheme certainly is not the type of "reasonable, certain and adequate" compensation which this Court has stated is necessary in taking cases. *See Williamson County Regional Planning Comm'n v. Hamilton Bank*, 473 U.S. 172, 194 (1985) (cited at Respondent's Brief at 11).

The Superintendent's attempt to dissuade this Court from reviewing the decision below based on the pendency of *Alliance*

of *American Insurers v. Cuomo*, 87 Civ. 0169 (Patterson, U.S.D.J.) also must fail. MMIA is not a party to the *Alliance* lawsuit. The issues of whether New York can compel MMIA to operate at a loss and whether MMIA has standing to assert a claim of confiscation are only before this Court, not the *Alliance* court. MMIA, through protracted proceedings below, has established that it is incurring huge deficits as a direct result of state-prescribed confiscatory rates. The New York Court of Appeals' holding that MMIA cannot assert a constitutional claim against this taking requires immediate review by this Court.

II.

Fifth and Fourteenth Amendment Protections Extend to Non-Profit Joint Underwriting Associations

Respondent's Brief seems to concede that MMIA would have a valid constitutional claim—so that the decision below would be clearly erroneous—if only MMIA had "investment-backed expectations" (Respondent's Brief at 7). However, no such criteria for fifth and fourteenth amendment protections are prescribed either by the Constitution or the decided cases. To the contrary, this Court in *California State Automobile Association Inter-Insurance Bureau v. Maloney*, 341 U.S. 105 (1951) recognized a due-process challenge by a state-mandated, non-profit automobile risk insurance pool. Confiscation was held not to be a factor only because the premiums chargeable were commensurate with the risks.

Similarly, lower federal courts have recognized due-process claims of non-profit entities. *See St. Francis Hosp. Center v. Heckler*, 714 F.2d 872, 875 (7th Cir. 1983) ("the government cannot prescribe rates so low that the result is a taking of property without just compensation") (citation omitted), *cert. denied*, 465 U.S. 1022 (1984); *Delaware River Port Auth. v. Tiemann*, 403 F. Supp. 1117, 1124-25 (D.N.J. 1975) (non-profit entity entitled to a reasonable and just rate, which enables it to maintain its operations), *vacated*, 531 F.2d 699 (3d Cir.), *reinstated on remand*, 421 F. Supp. 142 (D.N.J. 1976).

Both Respondent's Brief, at 4, and the decision below, *MMIA v. Superintendent*, 72 N.Y.2d at 766 (Petition, App. A at 13a) concede that the "funds and reserves of MMIA are held and invested separately from its members." Like any other state-chartered insurance company, MMIA sets aside funds collected from policyholders as reserves to meet obligations assumed under the policies.[4] The decision below would allow the State to take these funds—which already are woefully inadequate to meet outstanding policy obligations—without MMIA having any recourse under the fifth and fourteenth amendments.

As the states grapple with problems of uninsurable risks, the need for resolution of this issue becomes urgent. Should this Court decline to grant certiorari, other states likely will follow New York's lead in compelling state-created JUA's to provide insurance at inadequate rates for certain groups of persons within the states. Issuance of a writ of certiorari to the New York Court of Appeals will provide opportunity for this Court to define the permissible limits of state ratemaking authority so as to avoid the proliferation of unconstitutional rate schemes similar to that upheld by the decision below.

In *Duquesne Light Co. v. Barasch*, 109 S. Ct. 609 (1989), Chief Justice Rehnquist, writing for the majority, reiterated the principle that an unconstitutional result may be established where the total effect of the rate scheme is unreasonable. *Id.* at 617. It is the total effect of the rating scheme foisted upon MMIA that is challenged as unconstitutional. Whether a JUA can be compelled to operate at a loss for a period of at least fifteen years in the hope that the enormous deficits will be made up by speculative future surcharges is a question requiring review by this Court.

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4 MMIA's latest annual statement filed with the Superintendent shows assets of over $700 million and liabilities in excess of $1 billion. Medical Malpractice Insurance Association, 1988 Annual Statement 2-3 (1989).

CONCLUSION

For the foregoing reasons and those set forth in the Petition, it is respectfully submitted that the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX

Opinion and Judgment of the Court of Appeals of the State of New York

COURT OF APPEALS
STATE OF NEW YORK

1 No. 88

MEDICAL MALPRACTICE INSURANCE ASSOCIATION,

Respondent,

—v.—

MARIO M. CUOMO, &c. et al.,

Appellants.

MEMORANDUM

This memorandum is uncorrected and subject to revision before publication in the New York Reports.

Robert Abrams, Attorney General (Kathie Ann Whipple, O. Peter Sherwood, Richard G. Liskov of counsel) for appellants.

T. Richard Kennedy, Larry P. Schiffer, Michael A. Knoerzer, Paul D. Getzels, Richard J. Cairns, NY City, for respondent.

MEMORANDUM:

The order of the Appellate Division should be reversed, with costs, the preliminary injunction vacated, defendant's motion for summary judgment granted, and section 11 and section 40 of chapter 266 of the laws of 1986 declared constitutional. The certified question should be answered in the negative.

We have recently determined that the Legislature may require the Medical Malpractice Insurance Association (MMIA) to operate at a loss on a temporary or even continual basis in order to promote affordable medical malpractice coverage (*Matter of Medical Malpractice Insurance Assn v Superintendent of Insurance*, 72 NY2d 753, 766). In so holding, we rejected the argument that § 40 of the Medical Malpractice Reform Act of 1986 (Reform Act) is confiscatory as to MMIA because it authorizes the Superintendent of Insurance to consider future surcharges on insurance premiums in fixing present insurance rates and thus contemplates that MMIA may be required to operate at a deficit. Likewise here, there is no constitutional infirmity in § 11 of the Reform Act insofar as it directs MMIA to refund stabilization reserve fund charges collected on excess policies issued during the 1985-1986 policy year. As a creature of statute, MMIA had no vested property interest in those charges and it was within the Legislature's prerogative to direct a refund in an effort to reduce overall health care costs (*see*, *Matter of Medical Malpractice Insurance Assn v Superintendent of Insurance*, 72 NY2d at 766, *supra*). Nor can MMIA state any cognizable claim for the impairment of contract rights since the stabilization reserve fund charge on excess insurance policies was imposed by statute and not as the result of any bargaining between MMIA and its insureds.

* * *

Order reversed, with costs, preliminary injunction vacated, defendants' motion for summary judgment granted and section 11 and section 40 of Chapter 266 of the Laws of 1986 declared constitutional in a memorandum. Certified question answered in the negative. Chief Judge Wachtler and Judges Simons, Kaye, Alexander, Titone, Hancock and Bellacosa concur.

Decided May 2, 1989

Remittitur

COURT OF APPEALS
STATE OF NEW YORK

The Hon. Sol Wachtler, Chief Judge, Presiding

1 No. 88

MEDICAL MALPRACTICE INSURANCE ASSOCIATION,

Respondent,

—v.—

MARIO M. CUOMO, &c. et al.,

Appellants.

The appellant(s) in the above entitled appeal appeared by HON. ROBERT ABRAMS, Attorney General of the State of New York; the respondent appeared by WERNER KENNEDY & FRENCH, ESQS.

The Court, after due deliberations, orders and adjudges that the order is reversed, with costs, preliminary injunction vacated, defendants' motion for summary judgment granted and section 11 and section 40 of Chapter 266 of the Laws of 1986 declared constitutional in a memorandum. Certified question answered in the negative. Chief Judge Wachtler and Judges Simons, Kaye, Alexander, Titone, Hancock and Bellacosa concur.

The Court further orders that the papers required to be filed and this record of the proceedings in this Court be remitted to the Supreme Court, New York County, there to be proceeded upon according to law.

I certify that the preceding contains a correct record of the proceedings in this appeal in the Court of Appeals and that the papers required to be filed are attached.

/s/ DONALD M. SHERAW

Donald M. Sheraw,
Clerk of the Court

Court of Appeals, Clerk's Office,
Albany, May 2, 1989